

Surviving Creatively

**An Investigation into the Impact
of Work with People who have
Learning Disabilities on
Art Therapists Employed
in the NHS**

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Declaration by Candidate

I hereby declare that this thesis is my own work and effort and that it has not been submitted anywhere else for any award. Where other sources of information have been used they have been acknowledged.

Signature

A handwritten signature in black ink, consisting of several loops and a long horizontal stroke at the end, positioned to the right of the 'Signature' label.

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And I would very much like to thank my fifteen Art Therapist participants, without whom this work could not have been done

Abstract

This heuristic qualitative study is the first British art therapy study into the impact of working with people with learning disabilities on art therapists employed in the NHS, asking whether they could avoid burnout. The researcher had personal experience of the issues. Unlike most burnout studies, organisational, client-related and personal factors were considered, and the interaction between them was found to be important.

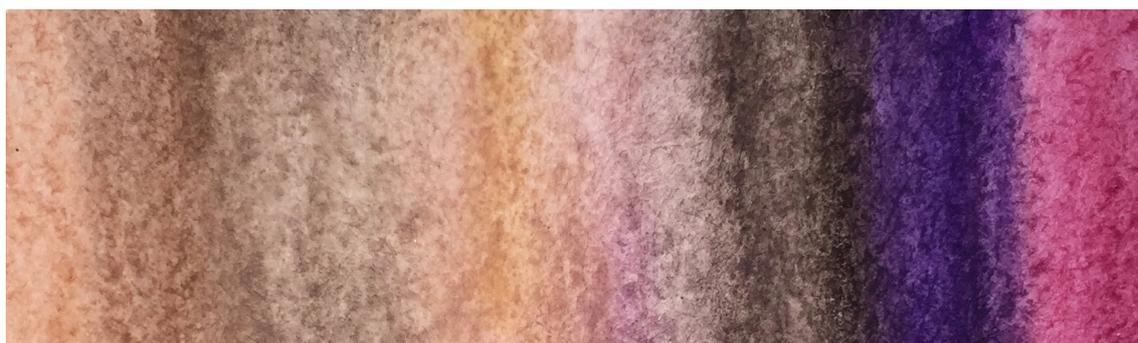
The researcher explored her own data in a rigorous self-analytic process, and fifteen art therapists employed by NHS Trusts across England were interviewed. There were enjoyable and satisfying aspects to our work as art therapists with people with LD, and protective factors, such as support, autonomy, empowerment, working part-time, personal development, art practice, and strategic self-care.

Researcher's data revealed considerable impact working with people with severe LD and challenging behaviour. Three participants had similar experiences, but, even for art therapists working with clients with milder LD, powerful unconscious processes impacted thinking and emotional labour, as did challenging behaviour, autism, complexity, risk, difficulties with engagement.

Stress was experienced due to widespread restructuring and ongoing change in NHS Trusts and prolonged job insecurity, uncertainty, work intensification and changes in working conditions. Limited employment opportunities for art therapists increased anxiety about job insecurity; fortunately, participants retained their jobs. They were highly committed, and most retained tenure for many years. Community-based art therapists were particularly impacted by agile working and estate reduction.

Personal sources of stress, combined with organisational and LD-related sources, and multiple roles, increased vulnerability to emotional exhaustion. Participants were creative, resourceful, flexible, and adapted to changing work conditions; they had a person-centred therapeutic approach, and made considerable efforts to ensure work-life balance. Of six participants who were highly stressed, three experienced emotional exhaustion and physical illness, but recovered, and there was much evidence of resilience and personal growth.

Table of Contents



Title Page	Page 1
Signed Declaration	2
Acknowledgments	3
Abstract	4
Table of Contents	5
Table of Illustrations	10
List of Acronyms and Abbreviations	12
Introduction	13
Chapter One: Art Therapy Practice, Methodology and Research Design	16
1.0 Introduction	
1.1 Art Therapy Practice with People who have Learning Disabilities	17
Benefits of using art in therapy for people with LD	
Transference processes	
Summary	
1.2 Situating the Research	26
Qualitative Research	
Social Constructionism	
Ontology and Theoretical Perspectives	
Heuristic Approach	
Reflexivity	
1.3 Heuristic Research	31
The Six Stages	
Differences between Phenomenology and Heuristics	
Different Heuristic Approaches	
Differences in my Approach	
1.4 Methods	36
Identifying the Research Questions	
Examining my own Experience	
Literature Search	

Upgrade from MPhil to PhD	
Gaining Ethical Approval	39
Sample	
Recruitment of Participants	
Interview Sites	
Anonymity	
Informed Consent	
Participant Information	43
Storage of Data	
Benefits and Disadvantages	
The Right to Withdraw	
Interviews	
1.5 Introduction to the Participants	46
Maria	
Stacey	
Walter	
Stephen	
Jayne	48
Sarah	
Simon	
Katie	
Andy	
Dan	49
Ruby	
Jill	
Joan	
Rae	
Lucy	
1.6 My Research Journey	51
Journey of Discovery	
Process of Analysis	
Meanwhile Normal Life Continued	
Impact of my Work on Me	
1.7 Data Analysis	55
Thematic Analysis	
Participant Portraits	
Transcripts	
Member Checking	
Immersion, Incubation and Illumination	57
Explication	
Composite Depiction	
Creative Synthesis	
1.8 Data Sources	59
1.9 Issues Addressed in the Research Process	60
Validity	
Insider and Outsider Research	
Voice	
1.10 Ethical Issues	62
Ethical Issues that Arose in the Planning of my Study	
Next	65

Chapter Two: The Literature Review	66
2.0 Introduction	
2.1 The Context of the Research	68
2.1.1 The LD Context	
What is a Learning Disability?	
Issues Experienced by People with Learning Disabilities	
Issues for Staff Working with People with LD	
2.1.2 The NHS Context	75
The NHS under Pressure	
Change for NHS Trusts	
2.1.3 Art Therapy in Context	80
Issues Encountered by Art Therapists	
2.2 Occupational Stress and Burnout	87
2.2.1 An Overview of the Occupational Stress Literature	
What is Occupational Stress?	
Occupational Stress Research	
Burnout	90
2.2.2 Occupational Stress and Burnout in LD Staff	92
2.2.3 Occupational Stress and Burnout in NHS Staff	95
2.2.4 Occupational Stress and Burnout in Art(s) Therapists	98
Burnout in Arts Therapists	
Job Satisfaction	
2.3 Resilience and the Management of Stress	103
Resilience	
Empowerment	
Creativity and Healing	
Wellbeing and Balance	
2.3.2 Self-Care Strategies	109
Image-Making as a Form of Self-Care	
Supervision	
Further Strategies Identified	
2.4 Chapter Summary	117
Next	118
Chapter Three: Autobiographical Background to the Investigation	119
3.0 Introduction	
3.1 Starting Work in the Unit	120
Journal Entry 1	
Journal Entry 2	
Journal Entry 3	
Journal Entry 4	
Self-Dialogue 16.03.2013	
3.2 The Next Five Years	125
Journal Entry 5	
Journal Entry 6	
Journal Entry 7	
Self-Dialogue 24.03.2013	
Journal Entry 8	130
Journal Entry 9	
Journal Entry 10	

Journal Entry 11	
Journal Entry 12	134
Journal Entry 13	
Journal Entry 14	
Self-Dialogue 12.03.2013	
Journal Entry 15	
Journal Entry 16	
3.3 After Moving Out of the Specialist Unit	141
Journal Entry 17	
Journal Entry 18	
Journal Entry 19	
Journal Entry 20	144
Journal Entry 21	
Journal Entry 22	
3.4 Restructuring in my NHS Trust	146
Journal Entry 23	
Journal Entry 24	
Journal Entry 25	
Journal Entry 26	
3.5 Issues that Emerged from my Reflections	151
In the Specialist Unit	
The Impact of Restructuring	
3.6 Chapter Conclusion	158
Next	160
Chapter Four: The Research Findings	161
4.0 Introduction	
4.1 Work Intensification, Job Insecurity and Ongoing Change	162
Widespread Change	
Job Insecurity	
Work Intensification	
Changes in Working Conditions	165
Difficulties with Working Environments	
Feeling under Attack	
Adapting to Change	
4.2 Relationships, Empowerment and Wellbeing	175
NHS Staff Relationships and Empowerment	
Client-Related Relationships and Empowerment	
Personal Relationships	
Wellbeing	185
Participants' Stress Levels	
The Less Stressed Group	
Stressed but Managing	
The Highly Stressed Art Therapists	190
My Experience of Stress	
4.3 Creativity, Personal Development and Self-Care	194
Creativity	
Personal Development	199
Self-Care and Stress Management	
4.4 Chapter Summary	206
Next	210

Composite Depiction	211
Chapter Five: Discussion and Conclusion	214
5.0 Introduction	
5.1 Wellbeing and Burnout	215
5.2 NHS, LD Client and Personal Pressures	219
NHS Pressures	
Emotional Labour in LD work	
Personal Stress Factors	
5.3 Factors Relevant to Art Therapists	227
Creativity, Resilience and Empowerment	
Art Therapists' Employment in the NHS	
Profile of Art Therapy	
5.4 Protective Factors, Self-Care and Stress Management	234
Organisational Protective Factors	
Client-Related Protective Factors	
Personal Protective Factors	
Self-Care	
Stress Management	
5.5 Application of the Heuristic Methodology, Limitations, Recommendations, and Post-Script	239
Application of the Heuristic Methodology in this Study	
Limitations of the Study	
Recommendations	
Post-Script	
5.6 Conclusion	243
Next	246
Then	
Creative Synthesis	247
Bibliography	248
Appendices	288
Appendix 1: Invitation Letter	288
Appendix 2: Participant Information Sheet	289
Appendix 3: Interview Schedule	293
Appendix 4: Consent Form	294
Appendix 5: Self Search	295
Appendix 6: Participant Portraits	297
Appendix 7: Validation from Participants	316
Appendix 8: Guide to the Images in this Thesis	320

Table of Illustrations

Banner Heading to Table of Contents. Fragment of ‘Shadows’, May 2016. Watercolour on watercolour paper, 6.5 x 7.5 cm.	5
Banner Heading to Introduction. Fragment of ‘Reeds’, April 2016. Watercolour on watercolour paper, 6 x 9 cm.	13
Banner Heading to Chapter One. Fragment of ‘Rich Tapestry 2’, April 2016. Watercolour on watercolour paper, 9 x 8.5 cm.	16
Figure 1: ‘Solitary Endeavour’, April 2008. Poster and metallic paint on watercolour paper. 60 x 42 cm.	30
Figure 2: ‘Art Journaling Process’, September 2009. Poster and metallic paint on cartridge paper. 60 x 42 cm.	38
Figure 3: ‘Mind Maps’, March 2010. Digital Photograph	45
Figure 4: ‘Endless Paper’, October 2010. Poster paint, photocopied photographs, and metallic paper on card.	53
Figure 5: ‘Process of Discovering Emerging Themes’, January 2012. Digital photograph.	59
Figure 6: ‘Example from Reflexive Journal’, April 2012. Digital photograph.	64
Banner Heading to Chapter Two. Fragment of ‘Mosaic’, March 2016. Watercolour on watercolour paper, 10 x 8.5 cm.	66
Figure 7: ‘Planes of Vision and Colour’, October 2014. Poster & metallic paint on cartridge paper; 30 x 42 cm.	67
Figure 8: ‘The Literature Review’, July 2011. Poster & metallic paint, fragments of typed & metallic paper on cartridge paper; 60 x 42 cm.	85
Figure 9: ‘Patterns of Paper Strewn Study’, February 2012. Typed pages, photographs of paper laid out on study floor, and paint. 60 x 42 cm.	102
Figure 10: ‘Acquisition of Knowledge’, March 2012. Poster paint, tissue & metallic paper, fragments of writing, on cartridge paper; 60 x 42 cm.	116
Banner Heading to Chapter Three. Fragment of ‘Rich Tapestry 4’, May 2016. Watercolour on watercolour paper, 8 x 7.5 cm.	119
Figure 11: ‘Gold Amongst the Chaos’, March 1998. Poster and metallic paint on paper; 60 x 42 cm.	122

Figure 12: ‘Sky-Change’, October 1999. Watercolour paint and coloured tissue paper on cartridge paper; 60 x 42 cm.	128
Figure 13: ‘Branching Out’, November 2000. Black and white lithograph print, printing ink on cartridge paper; 42 x 30 cm.	132
Figure 14: ‘Stress amidst Good News’, April 2004. Felt pen on paper. 60 x 42 cm.	140
Figure 15: ‘Out of Chaos’, June 2005. Poster and metallic paint on paper; 60 x 42 cm.	144
Figure 16: ‘Dark Landscape’, December 2012. Charcoal on cartridge paper: 60 x 42 cm.	148
Figure 17: ‘Contentment’, May 2016. Watercolour paint on watercolour paper; 8.5 x 7.5 cm.	160
Banner Heading to Chapter Four. Fragment of ‘Rich Tapestry 3’, May 2016. Watercolour on watercolour paper, 9 x 8.5 cm.	161
Figure 18: ‘Voice’, July 2014. Poster paint on cartridge paper, 60 x 42 cm.	170
Figure 19: ‘Participants’ Stress Levels’ Chart, April 2017. Digital file.	186
Figure 20: ‘Bronze Blue 2’, June 2016. Watercolour on watercolour paper, 9 x 8.5 cm.	197
Figure 21: ‘Diagram of Stressors and Protective Factors’, April 2017	204
Banner Heading to Composite Depiction. Fragment of ‘Rich Tapestry 8’, June 2016. Watercolour on watercolour paper, 7 x 8.5 cm.	211 213
Banner Heading to Chapter Five. Fragment 2 of ‘Rich Tapestry 4’, May 2011 Watercolour on watercolour paper, 9 x 8.5 cm.	214
Figure 22: ‘Connecting through the Rain’, July 2016. Watercolour on watercolour paper, 12 x 5 cm.	225
Figure 23: ‘Rainbow Seashore’, October 2016. Watercolour on watercolour paper, 30 x 42 cm.	233
Figure 24: Poem ‘Saving Howard’ on image ‘Complex Quilt – Multi 5’, September 2016. Coloured pencil on cartridge paper; 29.5 x 20 cm.	247
Banner Heading to Bibliography. Fragment 2 of ‘Mosaic’, April 2016. Watercolour on watercolour paper, 10 x 8.5 cm.	248

Acronyms and Abbreviations

ACT – Acceptance and Commitment Therapy
ADHD – Attention Deficit Hyperactivity Disorder
AT – Art Therapy
ATLD SIG – Art Therapy and Learning Disability Special Interest Group
AWOL – Absent Without Leave
Admin – Administration Tasks
BAAT – British Association of Art Therapists
BILD – British Institute of Learning Disability
CAMHS – Child and Adolescent Mental Health Service
CF – Compassion Fatigue
CLRN – Comprehensive Local Research Network
CPD – Continuing Professional Development
CPN – Community Psychiatric Nurse
CSA – Childhood Sexual Abuse
CSE – Core Self-Evaluation
DHSS – Department of Health and Social Sciences
DOH – Department of Health
DSH – Deliberate Self-Harm
EMS – Early Maladaptive Schemas
HCPC – Health Care Professions Council
GP – General Practitioner
IPA – Interpretative Phenomenological Analysis
IQ – Intelligence Quotient
IT – Information Technology
IRAS - Integrated Research Application System
KSF – NHS Knowledge and Skills Framework
LD – Learning Disability, or Learning Disabilities
MBI – Maslach Burnout Inventory
MDT – Multi Disciplinary Team
Master's – Master of Subject Level Degree
MPhil – Master of Philosophy
MRes – Master of Research Degree
NHS – National Health Service
OA – Older Adults
PCP – Person-Centred Models of Care
PhD – Doctor of Philosophy Degree
PRN – Pro Re Nata (meaning: as needed medication)
PTSD – Post-Traumatic Stress Disorder
R&D – Research and Development
REC – Research Ethics Committee
SALT – Speech and Language Therapist
SIG – Special Interest Group
TOIL – Time Off In Lieu

Introduction



This PhD study into ‘the Impact of Working as an Art Therapist with People with Learning Disabilities in the National Health Service (NHS)’, and its interest in avoiding burnout, is a heuristic and qualitative investigation, and the first of its kind in Britain. It came into being through my experience of work in that capacity and context, and my distress at a valued friend and colleague experiencing burnout that was not recognised as such by the organisation. The study answers the research questions, which are: ‘What is the impact on the art therapist of working with people with learning disabilities in the NHS?’ and ‘How do art therapists avoid burnout in their situations?’

The first chapter begins by describing art therapy practice, and then addresses the methodology employed in this research project, explains all the procedures and decisions taken during the research process, and introduces the reader to the participants. The second chapter presents the literature that grounds my study in the relevant knowledge and addresses evidence of issues that relate to my data; the gap that my study contributes to is evident, as no research into this subject has been undertaken by British art therapists.

Chapter Three investigates my experience of working as an art therapist in a specialist NHS facility for people with severe learning disabilities (LD), the difficulties I encountered in that context, and the experience of my colleague burning out; it also addresses my experience of restructuring within my NHS organisation at the same time as the participants experienced the same issues. These experiences aroused my concern with the subject and form the background to the investigation.

The fourth chapter examines the findings of the data drawn from the interviews with the fifteen art therapists working with people with LD in the NHS in England who I recruited

as my participants, incorporating my own data. The chapter shows how our work impacted our psychological and physical wellbeing, addressing it with a holistic approach that includes consideration of the interaction between organisational, client-related and personal factors, and how those relate to our capacity for resilience and self-care.

The Composite Depiction, a feature of the heuristic methodology, summarises the main characteristics and approach of arts therapists working with people with learning disabilities in the NHS, and is located after the fourth chapter.

The fifth and final chapter is a discussion of the issues raised in my analysis of all the data from the Autobiographical Chapter (Chapter Three) and the Participants' Findings Chapter (Chapter Four), bringing the thesis and Discussion to a Conclusion, drawing together the major threads of the investigation. Application of the heuristic methodology is also discussed.

The Creative Synthesis is located after Chapter Five, and is a poem and image inspired by my experience of my colleague burning out, and raises issues pertinent to my findings in this study. The Bibliography and Appendices form the final pages of the thesis.

The thesis is vivified throughout with images made as part of my creative process as an artist, art therapist and researcher throughout this research process. Moustakas (1990) encouraged a creative approach to heuristic research methodology, which is well suited to the task of exploring the meaning of people's experiences, and for creative people undertaking research into human experience.

The images at the start of each chapter root the study in a creative setting, and were made during the analysis stage of the Participants' Findings Chapter; each image is a fraction of a larger image, showing a detail that would otherwise be missed, and therefore they illustrate the research process well. In the Autobiographical Chapter, there are a number of images made during the time I was describing, and show something of what I was feeling and mentally processing. There are further images in each chapter that were made during the long process of the PhD and formed part of my self-care approach, or illustrate some aspect of the research process. These are discussed in Appendix 8.

The thesis is written in the personal voice, which is becoming more conventional in qualitative research reports (Esterberg, 2002), and in an easy to read style to make the text more widely understandable.

I have used several descriptors for people with LD, which are client, patient and service user, all of which are in common use within the NHS. I chose to use the descriptor 'learning disability or disabilities' rather than intellectual disability or another descriptor because it is currently in use in the NHS in Britain. For a fuller discussion of what a learning disability is, and relevant issues, see page 59.

I used two descriptors for the participants, which are art therapist(s) and participant(s); I did not use the term co-respondents which is conventionally used in heuristic research because the NHS IRAS process assumed and enforced distance between researcher and participants that normally would not normally have existed with this methodology, though I included them wherever possible. For information about art therapy see page 17 in Chapter One, and page 71 in Chapter Two.

Please note that when referring to clinical supervisors in a therapeutic work context the supervisor is engaged with the supervisee seeking to understand and process the nuances of the therapeutic work with their clients. This is not the sense that the research literature (such as Nolan, 2002) uses the term supervisor, which is more of a managerial role, nor the sense in which the term is used for supervisors of academic work, such as this thesis.

Care has been taken to protect the confidentiality of participants and colleagues, all of whom have been referred to using pseudonyms; the participants chose their own, and gave permission for inclusion of their transcribed data in this thesis.

It is my hope that this PhD study and thesis will add a valuable contribution to the evidence base of the profession, and one that will assist art therapists to recognise the need to attend with more care to their own wellbeing. Feedback from my participants suggest that it will (see Appendix 7).

Chapter One

Art Therapy Practice, Methodology and Research Design



1.0 Introduction

In this chapter I begin by describing art therapy practice with people who have learning disabilities, in order to contextualise the research for those unfamiliar with art therapy practice. This section of the chapter describes my experience of art therapy practice, how art is helpful for clients in the therapeutic process, and the role of unconscious transference phenomena, giving examples from practice.

The chapter then goes on to describe the strategy that I adopted for my research, and the justification for my approach in the light of the research literature is discussed. The art therapy literature barely addressed the issue of the impact of art therapy work on art therapists within organisations, in this case the NHS, and with particular client groups, and the gap in the evidence is very apparent, as I will show in my Literature Review in Chapter Two.

The research question was ‘What is the impact on the art therapist of working with people with learning disabilities in the NHS?’ and aimed to address the gap that was identified. In addition, I also sought to discover ‘how art therapists avoided burnout in their situations?’ My ontological, epistemological and methodological approaches are discussed, as are the ethical issues that were faced; the participants are introduced, and I describe the procedures followed in the process of data collection and analysis.

The background to the investigation was a personal experience of the impact of the art therapy work I was doing with people with learning disabilities within the NHS and therefore I was drawn to using a qualitative heuristic process. First, I interrogated my

own experience and then widened the investigation to include the experience of others who wanted to explore and understand the same issues in their own lives, a process developed and described by Moustakas (1990, 1994). This methodology is situated within a socially constructed view of the world, and phenomenological and hermeneutic philosophical approaches (Crotty, 1998). Key to the methodology is reflexivity and an awareness of the various selves I brought to my research (Reinharz, 1997), particularly my art therapist self and the psychotherapeutic and person-centred influence that has had on my thinking, my creativity and my spiritual approach to life.

In this chapter I describe how, having gained NHS ethical approval, I recruited fifteen art therapist participants, interviewed them, and transcribed the interviews. I used a qualitative, thematic and reflexive approach to the analysis of the findings, which are presented in Chapter Four and discussed in the light of the literature in Chapter Five. This chapter describes the overall approach in detail, and addresses pertinent issues relevant to the investigation and its position within a wider epistemological and ontological framework.

The first section of the chapter situates my research within its context of art therapy practice with people who have learning disabilities. The second section describes my methodological approach, and the third discusses the heuristic process in detail. The fourth section examines the methods used during the process of my research, I then introduce the participants and discuss my research journey in the next two sections. The process of data analysis is addressed, and the data sources are identified in sections seven and eight. The chapter concludes with issues addressed in the research process and ethical issues encountered.

1.1 Art Therapy Practice with People who have Learning Disabilities

Art therapy practice begins with the setting and referral, and proceeds through the stages of assessment, treatment, discharge and follow-up. In this thesis, I and the participant art therapists were working in the NHS, in psychology or arts therapies services, and in the context of community learning disability teams or inpatient/forensic services. Art therapy practice has been discussed at some length by many art therapists, for instance, in general terms: Case and Dalley, 2006; Dalley, 1984; Edwards, 2004; Waller & Gilroy, 1992; with people with LD: Bull and O'Farrell, 2012; Hackett et al, 2017; Rees, 1998; and with specific conditions and client populations: Case and Dalley, 1990; Dolphin et al, 2014;

Hass-Cohen and Carr, 2008; Killick and Schaverien, 1997; Liebmann, 1994; Liebmann, 2008; Liebmann and Weston, 2015; Murphy, 2001; Waller, 2002; Waller and Sibbett, 2005; Weston and Liebmann, 2015.

The setting required is one with a suitable room that has washable floor, a sink with running water, appropriate storage, furniture and art materials, and access to natural light (Edwards, 2004; Wood, 2000). The room needs to be located in a suitable environment that will enable the service user to wait for their session in a quiet area, and should not be subject to interruptions, noise, smells or other intrusions (Ashby, 2004).

In my team referrals are received centrally by the Community Learning Disability Team, and will indicate that a psychological intervention, or specifically art therapy, is appropriate. Referrals are discussed in the psychological services team meeting and allocated for an initial assessment; any member of the senior clinicians might undertake the assessment, often accompanied by trainees. As a senior clinician in the team, I undertake initial assessments for psychological interventions, giving my opinion afterwards in a team discussion, then the patient is allocated a clinician and the type of intervention decided on. For art therapy referrals, I would do a further assessment for art therapy.

A number of questions need to be considered in the assessment phase, such as:

- What is the referral about?
- Is a psychological intervention appropriate, and art therapy a good choice?
- What is the person's capacity, and how willing are they, to engage in a meaningful relationship with me, the therapist?
- What is their level of understanding and cognitive functioning?
- Are they willing to use art materials to assist the therapeutic process?
- Does the person need support for physical disabilities or issues such as epilepsy?
- Is a group or individual, open-ended or time-limited, intervention indicated?
- How much support will the person need to access their sessions regularly, and will that be forthcoming?

Beyond these questions lies the work that needs to be done, such as with the impact of early developmental delay, trauma, bereavement, abuse, neglect, disability, relationship

issues, autistic traits, challenging behaviour, physical health conditions, vulnerability, and communication difficulties, and possibly a combination of factors.

Once the assessment is completed and art therapy sessions agreed on, and the art therapist has capacity to accept the referral, an art therapy intervention is arranged. Timing of sessions often needs to be addressed with a carer or parent. Engagement can take some time for individuals who have autistic traits or bad experiences with professionals, and this needs to be allowed for with the LD population. Attendance can be problematic if the person needs to be escorted to their session (the escort will usually wait outside) and the organisation that supports them is somewhat chaotic. Many people with LD cannot read the time, resulting in them attending with somewhat erratic timing - mobile phones can be set up with reminders that can assist this issue, if the person has capacity to use such technology.

Once inside the art therapy room the person attending for art therapy is given choice about how they use the session time, the art materials they use, how much they talk, and the content of the session. The art therapist's psychodynamic training enables both conscious and unconscious processes to be considered, with a non-judgemental inquiring attitude of respect, empathy, compassion and hopefulness, enabling work with complex and multiple difficulties impacting the client's life. A brief explanation of the aims, objectives and boundaries of the session is given at the start of the intervention; goals may be identified, and in some cases a contract for sessions is drawn up.

Benefits of using art in therapy for people with LD

The art may be used in varying ways to assist the therapeutic process. A service user, aged 20, who was very autistic, in addition to having a mild LD and cerebral palsy affecting his mobility, was working as an intern in a hospital. He found the art therapy session extremely helpful in assisting him to think about and manage his feelings and responses to other people and situations. He drew while he talked throughout the session and this process helped him think, although he said little about the image, which was usually only partially completed, although it was of relevance to the issues he was discussing in the session. He found eye contact very difficult, so drawing relieved him of the necessity to look at me; it took me a while to get used to thinking about how he was feeling and his emotional material without being able to see much of his facial expression. At college having a mentor had assisted him with emotional regulation and

though he did have support at work this did not include emotional support, so the art therapy session was an important emotional and safe space that helped him cope with the demands of his life.

Another client, aged 18, with a history of childhood abuse, an autism diagnosis and attachment difficulties, attended art therapy weekly over a six-month period, for between fifteen and fifty minutes, building up her capacity to tolerate the intimacy of the therapeutic session, sometimes retreating and 'hiding'. She would flounce into the room and act out her feelings, talking loudly and rapidly, and made images that were always about her attachment to others, which she then gave to them, rarely making images for herself about her own process. She demonstrated a capacity to engage in ways that demonstrated developmental difficulties, very much on her own terms, and to develop a relationship, but when it came to ending did not seem to understand the need for a proper ending, perhaps never having experienced one. The sessions ended as the therapeutic relationship intensified and she could no longer tolerate the emotional content, however she knew she could return to art therapy if she felt the need in the future. In the meantime, the psychology team provided input to her carers to assist them to think psychologically about her needs.

A young woman of 25 who had had meningitis as a child and encephalitis, resulting in difficult to control epilepsy and a learning disability, really struggled to accept her disability, coming as she did from a middle-class family of some intellectual capacity, and being the only member unable to live a normal life. She did not feel she had any artistic ability, and began by making simple faces expressing emotions, and writing sentences on the paper. She had a capacity for understanding more complex words and concepts than the average person with a learning disability, but struggled to organise herself and to manage everyday aspects of life. I sent text reminders to her mobile, without which she would miss her session; she lived independently but was struggling to manage on her own. She attended individual sessions for two years, and during that time we worked on her accepting her disability rather than fighting it, and helping her to think about how to help herself. She did not understand humour, a symptom of her autism, which led to some difficult but important conversations. The images she made grew in artistic content, and definitely helped her to think during the session; they added a dimension to the talking that somehow grounded her thoughts and enabled her to hold onto them when feeling overwhelmed. She struggled to know what to draw but once she

realised she could draw her feelings she produced increasingly artistic images that illustrated her emotional state – for instance, drawing herself as two people looking overwhelmed with mountains in front, and described how the people felt they were falling off the mountain. Being able to articulate her emotional state in such a way was helpful to her.

An older woman, in her 40s, who had experienced abuse and neglect as a child and was still experiencing the emotional impact, demonstrated challenging behaviour and had a moderate learning disability. She attended an art therapy group which had six members, all with moderate LD, facilitated by myself and a trainee, for a year. She was able to depict her experience, whether of some event during the week or something of historical significance, in an image, but would remain distressed by it on leaving the session unless able to draw a ‘happy picture’. Therefore, she always drew two pictures, and the happy picture enabled her to put distance from the unhappy picture and its contents, and she could take the happy picture with her and deposit the unhappy picture with me. Thus, she was able to work through many distressing events from the past, with the support of other women in the group and the therapists, and her challenging behaviour consequently reduced.

Sensory aspects of the art materials are important for the art therapist to consider, particularly when working with people with severe autistic traits. Some materials are attractive to some individuals and repellent to others, and an awareness of the impact on individuals is important. One of the participants described having to provide edible art materials because of his challenging client’s propensity to eating them. Another of my older clients found paint reminded her of being at school, and found the smell very off-putting. Some people benefit from painting when they want to express some overwhelming feelings such as anger, but find the materials too overwhelming on a sensory level if needing to work with withdrawing feelings, and then coloured pencils and felt tips can be helpful, providing a distance from the disturbing feelings.

These examples demonstrate some of the ways in which the artwork assists people with learning disabilities to think about, communicate and process their emotional material. The image-making gives them an essential added element to therapy, beyond speaking about their issues, which for many of them would have been very difficult without the

creative process. The art in art therapy gives service users another language or form of expression that enables them to communicate what is hard to articulate and process.

Once clients have reached what seems a good point for ending the therapeutic process an end point is identified and worked towards, with the aim of achieving a 'good' ending if possible. This is helpful if achievable as clients have often experienced being abandoned or rejected, and a good ending can assist some reparation of those wounds. The artwork produced in therapy, which has been treated as confidential material and carefully stored by the therapist until the end of treatment, is usually looked at during the ending process. Usually a development is apparent in the images that reflects the progress made in therapy, and looking at the images in this way can be very helpful to the patient. The person is given the option of taking their images home, or leaving them with the therapist. There can be some danger in taking the images home, as often they are not 'nice' images suitable for display, and carers may not value the emotional importance they have for the individual. For this reason, some service users opt to leave their images with the therapist, and we have an obligation to store them as confidential material for two years, after which they must be destroyed. During the two years clients may ask for their images and we will ensure they returned to the individual.

Transference processes

Art therapy practice also includes consideration of our psychodynamic understanding of unconscious processes of transference and counter-transference, which along with image-making are central to the art therapist's understanding of what is happening in therapy with their clients (Dalley, 2000). Transference occurs 'when the patient transfers strong, infantile feelings that originate from childhood experiences or early relationships onto the therapist' (Case and Dalley, 2006, p.77); the counter-transference is 'the therapist's response, and the feelings that are aroused, by the interaction with the client and the image in a therapeutic situation' (Case and Dalley, 2006, p.80).

One misconception about art therapy is that it is a non-verbal form of creative psychotherapy. In fact, the talking aspect of art therapy is very important, and without that all we have to rely on is the countertransference and the image to provide us with information about what is happening in the session. For clients who have speech, it is necessary to couch our words in simple language, as people with LD are not able to understand complex words and phrases, and are alienated by them. It is helpful for

therapists to re-state what they think a client has told them in order to check whether they have understood them, and to demonstrate they have really been listening.

The behaviour of the client and the feelings experienced by the art therapist during sessions inform the therapist about the transference process that is at work in the session, and if this is confusing, as it often is with people with LD, clinical and peer supervision are helpful in unravelling what is happening. This process is emotionally demanding and is described in the literature as emotional labour. The therapist needs to understand their own emotions and responses in order to engage in the understanding process, which experience of personal therapy during training greatly assists.

In Chapter Three there is an account of my art therapy practice with people with severe LD and challenging behaviour, which forms the background to the investigation. My therapist colleagues and I sought to understand the clients' behaviour and what it meant, and to consider its impact on us, and much of my understanding was gained from my training in object relations theory and my experience as a parent. Object relations theory, which stems from psychoanalysis and the writings of Klein (1932) and Anna Freud (1986), resulted in the development of child psychotherapy, and concerns the development of a baby's understanding of its inner reality and relationships with others. Winnicott's developments of this understanding have been particularly important for art therapists, such as his ideas of the facilitating environment, the good enough mother, creativity, transitional objects, the importance of play, the safe space, maturational processes, the mother's gaze, and the hopefulness of delinquency (Winnicott, 1971, 1986, 1990, 1992).

A learning disability is experienced from birth, and delays the development of individuals so that in many ways they may appear child-like, as their cognitive functions have not fully developed. Consequently, many people with LD are stuck in the developmental process unable to complete individuation and reach mature levels of understanding, communication and functioning in the world. Sinason (1992) provided much useful information about conducting psychotherapy with people with LD, and showed that it was an effective treatment for people with LD; she also shed light on how the impact of the work could manifest for the therapist as a result of the countertransference.

The countertransference is therefore a very important aspect of our practice and also a source of stress and difficult feelings. This therapeutic process has been mentioned in the Literature Review in Chapter Two, in the Autobiographical Chapter (Three), and in the Findings Chapter (Four), but this section aims to clarify what the countertransference is, and the different ways in which it is manifest in art therapy practice through examples.

The emotional ‘blanket’ that can feel like it is descending during sessions, particularly with people who have severe LD or significant difficulties with thinking processes, is a form of countertransference that I came to dread when I was working in the specialist unit, as you will read in Chapter Three. It feels like you are being anaesthetised and sent into a deep sleep, which as the art therapist in a session you must fight, but it demands much of you to fight it. I found that engaging in simple artwork alongside the severely learning-disabled client could help me to focus my thinking and stay in the present. In situations where the art therapist makes images alongside the service user it is important to consider what is revealed by their image, as much as that of the image the patient produces.

In the specialist unit (see Chapter Three), we experienced extremes of emotions in the countertransference, because the clients were unable to communicate much vocally and to a great extent their communication took place in unconscious processes like introjection, projection and projective introjection. These processes feel like the emotions are being pushed into you, and the therapists in the specialist unit experienced the same feelings of frustration, anger, uselessness and rejection that the service users were observed, by means of their behaviour, to be feeling. Organisational processes, such as splitting between different managers and organisations, the difficulties faced, and long periods of time in which one’s voice is not heard within the organisation to address lack of resources or staffing issues, are difficult. They contribute to the staff experiencing emotions at heightened levels, because the service users’ problems are echoed in the organisations’ processes and consequent marginalisation of staff and service users. Being exposed to these extremes of emotions (identified by other art therapists in my MRes research, Ashby, 2004, 2011) is very demanding for therapists, and can lead to emotional exhaustion if too much time is spent in such units.

The intensity of countertransference experiences seems to reduce as the level of learning disability moderates, although it is always present in art therapy sessions. A woman in

her 30s who had a mild LD but severe and uncontrolled epilepsy came to sessions expressing hatred and anger towards her older sister, whose children had been taken into care because of their mother's neglect. This woman could not have children of her own and valued her relationship with her nephews and nieces, and in the countertransference during these sessions I experienced a mild version of the blanket effect (but enough for me to have to fight it), and a physical sensation of discomfort. Rothschild (2006) identified physical processes of arousal in the autonomic nervous systems (ANS) of our bodies that are activated during therapy sessions, and as a result of our empathic engagement with our clients. Rothschild encouraged therapists to work at managing their ANS arousal, balance their empathic engagement, and maintain the ability to think clearly. These are processes that are obviously at work in the countertransference when art therapists are working with people with LD, and some of the participants clearly described the impact of the work on their thinking processes (see Chapter Four); they can be quite debilitating, as I observed in Chapter Three. Mirroring behaviour in therapists can also be quite revealing and further evidence of the countertransference response, and is also an aspect of 'Intensive Interaction' (Hewett et al, 2011), a method of communication with people with severe LD.

The image can hold some of the impact of the countertransference, and therefore have a protective function, in that behaviour that might be acted out in sessions may be described as an event happening in the image. For instance, one of the participants described her client drawing her locked in a building and being abused (see Chapter Four), an account of the patient's own experience. Distinguished art therapist Schaverien (1992) has theorised about the embodied nature of some images, which invests them with life and emotions, and the opposite impact of the diagrammatic image lacking those qualities. Although the theory has been contested, for instance by Mann (1989), art therapists are aware of these, and similar, processes at work in their service user's image-making. The image can protect the therapist by enabling discussion of the emotional material which has become visible. However, in LD work some clients are unable to reach a point where their image-making is at a sufficient level of sophistication for it to reveal emotional material and make it available for discussion; the clients I worked with in the specialist unit, described in Chapter Three, were only able to produce pre-representational images of a scribble nature.

It is my experience that the art therapist's own image-making, in a session where thinking is particularly impeded or the countertransference impact is experienced as debilitating, is protective of their thinking capacities and also serves to reduce the ANS arousal level.

In addition to their professional training, as described above, art therapists also incorporate other useful skills into their practice. These include: Intensive Interaction (Hewett et al, 2011) and Gentle Teaching (McGee et al, 1987) in work with people with severe LD, systemic practice with carers, normalisation (Wolfensberger, 1983), sandplay, Theraplay (Booth and Jernberg, 2009) and other appropriate skills such as the use of specialist art materials like mosaic, glass painting and clay techniques.

Summary

This opening section of the thesis describes processes that are at work in art therapy practice with people who have learning disabilities, and sets the scene for the research. The particular importance of the artwork in art therapy has been described, and unconscious transference processes have been discussed, particularly countertransference, in the light of the impact on the person of the art therapist and their practice with people who have LD.

1.2 Situating the Research

This section addresses an outline of my approach within the qualitative paradigm and social constructionism, my ontological, epistemological and theoretical perspectives, using the heuristic research approach, and addressing reflexivity.

Qualitative Research

Qualitative research offered the most appropriate paradigm in which to situate the research, given the opportunities it afforded to gain an understanding of issues through gathering rich and descriptive data, which could not be achieved using quantitative approaches. This approach is widely used in social research because of its suitability for the scrutiny of social phenomena in context, which was the intention (Esterberg, 2002). Qualitative researchers value reflexivity in their methods, identifying clearly who the researcher is and making their attitudes transparent, within a process of contextualising research (McLeod, 2001), in contrast to a positivist approach (Crotty, 1998). Hence the qualitative research paradigm was a good fit for my purpose, although some quantification was relevant when aspects of the data were discussed (Patton, 1990).

There are drawbacks to qualitative research as questions of credibility and validity are more complex than in quantitative research (McLeod, 2001). This was addressed by working on achieving methodological rigour through good practice in the conduct of the research, and interpretative rigour regarding the trustworthiness of interpretations made. The research was systematic, although not in a linear sense, and consistent with its philosophical stance and aims (Fossey et al, 2002).

Social Constructionism

Many human science researchers consider the world to be socially constructed and people to engage in constructing meaning and knowledge within historical and cultural contexts (McLeod, 2001). People are active rather than passive about processing knowledge and inventing models, schemes and concepts to make sense of their experiences, and doing so within communities with shared understanding, language, processes and so on (Schwandt, 2003). Meanings that are ascribed to objects or events influence how people view, use or react to them, and these meanings are a result of social interaction and relating, and a process of interpretation, bringing together objectivity and subjectivity (Crotty, 1998). For some scholars, interpreting social reality is very similar to meanings that are sought in psychotherapeutic clinical work (Esterberg, 2002), a point that is particularly relevant for me.

My thinking, training and experience as a therapist informs my approach to learning and leads me to seek to understand the meanings that people have constructed as a result of their experience, which I approach holistically. I make links to their history and personalities that have developed as a result of inherent, environmental and experiential factors (such as their upbringing, key life events and their personality traits). Consequently, as a researcher my natural attitude is to approach my research in the same manner, and to contextualise the research and myself as researcher within the appropriate cultural and historical settings (in this case, the NHS within Britain in the second decade of the 21st Century).

Ontology and Theoretical Perspectives

As a Christian, there is a powerful spiritual dimension to my life, and I am passionately concerned with equality, relationships, social justice, and care for the planet, which is concordant with my feminist awareness and artist identity. In terms of the philosophical basis for my chosen methodology phenomenology and hermeneutics play important roles.

Although the heuristic approach is broadly phenomenological there are four differences noted by Moustakas (1990) that are explored in the next section and concern retaining connectedness with, and the voice of, participants. Some aspects of hermeneutics are relevant for my work, particularly that of locating the research in its cultural and historical context (McLeod, 2001); this is particularly important as the NHS is experiencing wide-ranging change in response to political and economic pressure, and these pressures have had a direct impact on the findings.

My training as an art therapist has influenced my thinking in psychotherapeutic terms fundamental to my work, and therefore also to my approach as a researcher, particularly psychodynamic and humanistic theories. Psychodynamic theory was initially developed by Freud, whose ideas about the unconscious were fundamental to the practice of psychoanalysis, which grew from his investigations into the working of the human mind (Bornstein, 2004). Psychoanalysis became a psychological treatment for emotional, relational, psychological and physical difficulties that are thought to have psychological origins in the unconscious mind (Brown & Pedder, 1979/1991). Jung's work with images was also important to the development of art therapy theory about the unconscious meaning of images, and importantly counterbalanced Freud's more negative attitude to art (Case & Dalley, 2006).

An aspect of psychodynamic theory that underpins the training of art therapists is object relations theory. Psychoanalysts such as Klein, Winnicott and Bion further developed complex theories about infant development through different stages of individuation in childhood, resulting in the adult's ability to function with ever-growing maturity as an individual in society if all proceeded as it should (Flanagan, 2016). Psychotherapists, and art therapists, consider meaning clients attribute to key events and relationships in childhood and the subsequent impact of these on their lives (Brown & Pedder, 1979). Winnicott's ideas about the use of 'potential space' and play have been of particular importance in art therapy practice (Edwards, 2004).

Humanistic psychology emphasises a holistic approach to psychotherapy, and a non-directive and client-centred attitude marked by genuineness and positive unconditional regard that was developed by Rogers. A shift from the intrapersonal to the interpersonal and increasing transparency on the part of the therapist was part of the development of Rogers' later person-centred approach (Hurding, 1985).

These aspects of psychotherapeutic approaches are fundamental to my thinking processes and therefore to my search for meaning in the research process. They are also key to the emphasis I place on psychological aspects of human experience and on a contextualised and holistic approach, and my reflexivity and transparency as a researcher. In addition, they are congruent with my Christian faith and feminist views.

Heuristic Approach

The overall approach is heuristic because the investigation is rooted in my personal experience of the phenomenon that I am researching, an investigation of human experience that has social significance. Within this approach the autobiographical experience initiates formation of the research question, which is then investigated in a process of exacting self-search. Through this the researcher discovers the nature and meanings of the experience, and develops procedures for further investigation (Moustakas, 1990, 1994).

Reflexivity and transparency are fundamental to heuristic methodology because the initial focus is on the person and lived experience of the researcher, and the self-discovery which results from the initial phase of the investigation informs the process that will follow (ibid.); however, the process is not about the researcher but about the human experience that is being investigated (Gilroy, 2006). The Autobiographical Chapter of this thesis (Chapter Three) gives an account of the events that initiated the research question: my experience of occupational stress while working as an art therapist in a specialist NHS unit with people who had severe learning disabilities and challenging behaviour, and the experience of a colleague who subsequently burnt out. The chapter also forms the outcome of the self-search, taking a constructionist form working from the researcher outwards towards the culture in which they are situated (Gergen and Gergen, 1991; McLeod, 2001). The whole research process was informed by the autobiographical account, self-search, literature, and iterative processes, and by the findings as they emerged in an organic, cyclical (and somewhat messy) progression (West, 2013).

The heuristic method Moustakas (1990) outlines incorporates creative aspects of discovery and aims ultimately to produce a ‘creative synthesis’, which, in addition to the research report may also incorporate creative artefacts, such as images, poems, stories and so on. For me, as an art therapist with personal experience of a phenomenon she wants to investigate, the heuristic methodology is congruent with my approach to life and

work. Heuristic methodology attends to power relations within the research process; it aims to give participants a voice, and opportunities to respond to the data as it unfolds and thus further impact the process (Moustakas, 1990; Rose and Loewenthal, 2006). A detailed description of the heuristic approach will follow in the next section.

Reflexivity

The use of self in the research process is at the heart of reflexivity as it is in the heuristic approach, which is pivotal to the honest self-disclosure of the researcher (Moustakas, 1990). Reflexivity is a skill that therapists develop so it is a natural attitude for therapists who become researchers (Etherington, 2004a) and the skills that art therapists develop for practice translate well into research skills (Gilroy, 2006; Thorpe, 2013).



Figure 1: 'Solitary Endeavour', April 2008

Reflexivity required me to be transparent about biases and pre-conceptions I brought to the research, and to be aware of my personal impact on all aspects of the process, including the balance of power between researcher and participant (Reay, 1996). Reflexive researchers aim to reduce the power imbalance by recruiting participants who will take an active role and make a positive impact on the process themselves (Ellis et al, 1997). I addressed this by giving the participants every opportunity to provide feedback

on each stage of the research process. Reflexivity in my research involved some personal risk as I opened myself to criticism through self-disclosure, but also involved valuable personal growth and contributed to the quality of the research inquiry (Etherington, 2004a).

1.3 Heuristic Research

Moustakas, a psychologist, person-centred psychotherapist and phenomenologist, developed heuristic research in response to a need for a qualitative methodology that would enable him to research the essence of an experience he identified as significant in his own life, which was socially significant, and to discover how others experienced the same phenomenon (Moustakas, 1990). His research into the experience of loneliness touched many readers, thereby demonstrating testimonial validity, and was published in a book that was the creative synthesis of his research (Moustakas, 1961/1989); a second book of letters from readers demonstrated how it had touched them (Moustakas, 1975).

Moustakas situated heuristic research within a frame of transcendental phenomenology, highly influenced by Husserl's philosophical stance but with significant differences (Moustakas, 1994). He described the heuristic process as having six stages.

The Six Stages

Initial Engagement

The first stage Moustakas identified is the researcher's initial engagement with the topic, which involves a process of consideration and identification of the research question(s). During this period, the investigator draws on their personal experience of the phenomenon, their intuition and tacit knowledge (those aspects of knowledge we know instinctively, discussed by Polanyi (1964, 1966)) pertaining to the subject, and attempts to establish the dimensions of the research. Self-search and dialogue are part of this process which results in the formation of research questions (Moustakas, 1990). Researchers may avoid addressing painful personal experiences by addressing a related but less painful topic (Sela-Smith, 2002), though I did not.

Immersion

Once the process has begun the researcher engages in a period of deep immersion in the material and the subject, being alert to references to the subject in different settings, engaging in aspects of self-search and self-discovery, pursuing clues and considering tacit

knowledge. Everything related to the phenomenon is drawn on during this period and can lead to an amazing process where the topic appears everywhere (Moustakas, 1990). Research that neglects immersion will lack integrity (Sela-Smith, 2002), however researchers need to take care that they do not drown in their own material, a common experience that I did not escape (Etherington, 2004b).

Incubation

Incubation is a period of withdrawal from deep engagement with the topic, putting distance between themselves and the material that hitherto the researcher has been working with, allowing absorption of the material and growth of understanding to take place. During this process the tacit dimension operates and brings new understanding on unconscious levels (Moustakas, 1990).

Illumination

The fourth stage, illumination, happens naturally when the researcher is open and receptive and results from knowledge gained during the previous two stages. In this stage awareness of previously undiscovered or unrealised aspects breaks through into the consciousness of the investigator.

Explication

The purpose of explication is to examine all that has been brought to consciousness in order to examine the various multiple layers of meaning that have been discovered; a comprehensive appraisal of all the information gathered enables the researcher to identify new themes and aspects previously unidentified. Processes utilised during this phase include focussing, indwelling, self-searching and self-disclosure, with an awareness of all aspects of reflexivity relevant to the inquiry. When the data has been collected and analysed individual depictions of participants can be produced, leading to a comprehensive depiction of the core themes (Moustakas, 1990).

Creative Synthesis

Once the final stage is reached the researcher has gathered all the data and is immersed in all the major aspects, qualities, themes, meanings and details of the research as a whole. The creative synthesis demands the use of tacit and intuitive faculties and usually takes the form of a narrative depiction illustrated with verbatim material from participants and examples; the creative synthesis may also take the form of a poem, story, painting or other

creative forms of expression. A thorough knowledge of the data and a period of solitude and meditation are necessary to bring the creative synthesis to fruition (ibid.).

Moustakas identified several processes within the researcher that are useful for this research method: self-search, tacit knowledge, intuition, indwelling, focusing and the internal frame of reference, the use of which in the different stages has been noted. Moustakas warned that the heuristic process is a demanding one, with which West concurs (2013); it involves the risk of self-disclosure and immersion in the material, and careful checking and re-checking of the material and understandings arrived at to ensure methodological and interpretive rigour. The voice of the researcher must be heard and the background in which the research is situated made apparent.

Differences between Phenomenology and Heuristics

Heuristics are phenomenological but Douglass and Moustakas (1985) identified four areas in which heuristics diverged:

- 1) heuristics emphasises connectedness and relationship in comparison to the detachment that phenomenology is generally associated with;
- 2) heuristic research produces depictions of meaning and portrayals of personal significance as compared to phenomenological depictions of the structure of experience;
- 3) heuristic research concludes with a creative synthesis as compared to phenomenological depictions of distilled experience;
- 4) in phenomenology the voices of participants are lost, whereas in heuristics the participants remain visible

Different Heuristic Approaches

Sela-Smith (2002) argued that there is some ambiguity in Moustakas's method as a result of the experience of unbearable pain, which resulted in him moving from self-search to a search for meaning with the involvement of co-participants. Her meta-analysis of 28 heuristic studies found that only three were self-searches, and the rest involved co-participants (Sela-Smith, 2002). Sela-Smith's analysis is not wholly without merit, as I found Moustakas's descriptions of the stages did not make it clear where the participants fitted into the process. However, there was clarity about the flexible, intuitive and organic approach Moustakas encouraged, suggesting that a rigid adherence to a prescriptive process was not what he was advocating. That so many heuristic studies involved

participants suggested to me a strategy that could be used in two ways, firstly inherently as a self-search as Sela-Smith (2002) and Fenner (1996) used it. Secondly it could be used as a constructionist research process that begins with the researcher's experience and reaches outwards to others who share the experience, which was my approach.

A formulation for heuristic inquiry with participants that differs from Moustakas's own was described by Rose and Loewenthal (2006) who suggested the following eight stages:

- 1) defining the research focus,
- 2) recording the researcher's personal experience,
- 3) identifying potential participants,
- 4) recruiting participants,
- 5) data generation,
- 6) immersion,
- 7) incubation
- 8) creative synthesis

Rose and Loewenthal particularly valued the relational aspect of heuristic research, as they interpreted it, and considered it to be a desirable method for interviewing participants in research which begins with the researcher's personal experience, as mine did. Their formulation appears to miss out the explication stage but was modified as a result of the researchers' experience of doing heuristic research. However, they seem to have described a linear process, which Nuttall points out does not allow the inquiry to 'unfold in its own way' as Moustakas suggested (Nuttall, 2006: 430), and Stephenson and Loewenthal (2006) described an iterative process that was cyclic.

A combination of methods, which included an interpretative phenomenological approach (IPA), case studies, reflexive action and writing, as integral to the six stages in his heuristic study into integration in psychotherapy were described by Nuttall (2006). He considered that heuristic research allowed use of a variety of appropriate strategies that resulted in deep engagement with the topic and researcher permeability.

Engaging in the heuristic process can result in transformation for the researcher, as Etherington (2004b) observed in students, and found in her study of the impact on counsellors of doing heuristic research. Etherington advocated a combination of heuristic

and postmodern methodologies, which she argued could provide greater balance between the personal and social emphases in heuristic research.

These differing opinions suggest flexibility in researchers' methods of conducting heuristic research and of data collection, indeed Moustakas promoted the idea that heuristic research is intuitive and gains its own momentum which the researcher must go with. There is, of course, no argument with the pre-requisite that the whole process must be underpinned by the researcher's personal experience, involvement and transparency, as pivotal to the research process.

The heuristic process was appropriate for my research firstly because of the pre-requisite that the phenomenon investigated must have personal significance for the researcher who has experienced it first-hand. Secondly, the connectedness and relational nature of heuristic inquiry is a necessary component for my study as, like Mahony (2010), I considered using a phenomenological approach because of the emphasis that was placed on investigating lived experience, but that approach seemed too detached and the experience too distilled. Thirdly, the emphasis on researcher creativity and creative synthesis makes the heuristic process congruent with my background as an art therapist and artist. Fourthly, the awareness the researcher is expected to have of both conscious and unconscious aspects of the knowledge investigated is another aspect of this approach that is congruent with my psychotherapeutic thinking.

Differences in my Approach

I departed from Moustakas's approach in situating the research within the historical and cultural context of the NHS in England in 2012, reminiscent of hermeneutics, which retains the fullness and context required but places an emphasis on the analysis of texts. The hermeneutical phenomenology of the philosopher Heidegger was pertinent, as, in seeking to understand the essence of Being, of everyday human experience, Heidegger employed a hermeneutical stance to his phenomenology because phenomena always require interpretation within tradition and history (Moran, 2000). Heidegger utilised the 'natural attitude' and considered it the most important focus (whereas phenomenologists try to 'bracket' it off); for Heidegger the 'natural attitude' was equivalent to the 'fore-understanding', an interpretive framework through which the world was understood. Heidegger fused these ideas from hermeneutics and phenomenology and created an

approach that combined them and greatly aided the task of understanding existence (McLeod, 2001). It is a combination of the heuristic approach and Heidegger's fusion of phenomenology and hermeneutics that I adopted in order to construct the best 'fit' for my study as Nuttall (2006) did.

I also spent some time attempting to use interpretative phenomenological analysis (Smith, 2009) as an alternative methodology, and to analyse my data, but found that although IPA would have been an appropriate methodology for my research, somehow it did not work for me. I concluded that the heuristic methodology was indeed the most appropriate, and used thematic analysis to assist my thinking about the analysis stage (Braun and Clark, 2006).

My initial engagement and self-search enabled me to identify the research questions, and cycles of immersion, incubation and illumination at that stage resulted in the autobiographical chapter which follows the review of the literature, and forms the background to the investigation. The explication stage involved many further cycles of immersion, incubation and illumination, which I found a very natural and helpful process, as I analysed my data and worked towards producing this PhD thesis, images and the creative synthesis, which is an image and a poem, and can be found at the end of the thesis before the bibliography.

1.3 Methods

Identifying the Research Questions

At the start of my research process I spent some time identifying the research question, which showed many possibilities that had to be narrowed down to a manageable focus. I was clear that I wanted to investigate experiences of occupational stress in the context of NHS work as an art therapist with people who have learning disabilities, but unclear whether this was related to working with the client group or difficulties with the organisation or the working environment, all of which were likely. Reading the occupational stress literature suggested that there were two possible outcomes of occupational stress for art therapists, which were burnout and compassion fatigue (or secondary traumatic stress), and in some contexts vicarious traumatisation might be applicable. I also sought to discover how art therapists coped with occupational stress and avoided burning out.

Two years earlier I had undertaken survey research into the working methods and working conditions of art therapists who worked in the NHS with people with severe learning disabilities and challenging behaviour, and a small amount of data about the impact of the work was gathered in that context (Ashby, 2004, 2011). However, during the process of identifying the research question I concluded that the impact was the most important aspect, though all the other issues appeared to be bound up in that. I narrowed the question by restricting my criteria to art therapists working in the NHS. The research questions therefore were ‘what is the impact on the art therapist working with people with learning disabilities in the NHS?’ and ‘how do art therapists avoid burning out in this context?’

Had the ethical permission process been simpler my question would have addressed the work of art therapists with people who had severe learning disabilities and challenging behaviour, but the NHS recruitment procedure was too complex to be able to identify art therapists working with this level of specificity.

Examining my own Experience

I engaged in a lengthy examination of my own experience, which formed the background to the investigation and was documented in the autobiographical chapter which follows the literature review (chapter three). I engaged in the process of self-search, described by Moustakas (1990), involving processes of self-dialogue, which I recorded in my research journal to elucidate the aspects of my experience that were important to answer the research question, three examples of which are provided in my autobiographical account. The examples show how I risked self-disclosure but also how illuminating the process can be. From immersion in this process emerged the research questions and an understanding of the issues that had affected my colleagues and me, a sense of who was appropriate to recruit as my participants, and decisions about the research process to be adopted.

Literature Search

The literature search, presented in Chapter Two, proved to be a lengthy process because there was so little literature of direct relevance to my research question, and barely any that was research-based. Through my earlier research I had gained familiarity with the literature on art therapists working with severe LD and challenging behaviour and within this there was some limited reference to the impact of the work. I investigated art therapy

research into the impact of the work and found very little, so widened the search to that of arts therapists and found a little more. I also addressed the issue of working environments for art therapists, of which much is written but little that addressed the impact on therapists, and consulted the literature on organisational dynamics. Having found little relating to the impact of the work on the art (or arts) therapist I widened my search to psychotherapists, whom I found had written much on the subject. I also consulted the literatures on occupational stress research and heuristic research.

Upgrade from MPhil to PhD

By 2011, the point at which I was applying to the NHS for ethical approval, I also submitted my partly formed thesis for upgrade from MPhil to PhD status. The examiners required me to consult the literature pertaining to NHS staff and remove what I had written about psychotherapists and then re-submit the work, after which it was passed.



Figure 2: 'Art Journaling Process', September 2009

Thus by the end of this process I had consulted several bodies of literature relevant to my research question, and had identified the gap that my research would address, as no British research into the impact of the work on art therapists had been conducted.

Gaining Ethical Approval

The research process was granted ethical approval by Goldsmiths College, but the process of gaining approval from the NHS Research and Development Department (R&D) within the local Comprehensive Local Research Network (CLRN) took nearly two years to complete, pushing the deadlines back and lengthening the time the research took.

In 2011 I attended an NHS research ethics committee (REC). Members of the committee were not receptive to qualitative research with staff and required a number of changes in the research process, the result of which was that I decided not to conduct a survey across the profession, which I had intended to do and would have given me some quantitative data to work with. The NHS system is not geared to manage research conducted with and about its staff and assumed that research would address the testing of medication with patients, and therefore the IRAS (Integrated Research Application System) forms that were submitted were almost wholly inappropriate for my purposes.

Fortunately I gained assistance from a CLRN advisor, who gave me advice on the process and assisted every step of the process after the REC meeting. When I was ready to attend the REC again a year later the rules had changed and I did not have to undergo the procedure again.

Once my local CLRN had given the go-ahead individual R&D applications had to be made to each NHS organisation that might employ art therapists willing to be participants in the research before I could make contact with any art therapists to invite them to participate in the study. This process was what made it impossible to find art therapists working with people with severe LD and challenging behaviour, as it was difficult enough to predict which of numerous NHS Trusts would employ art therapists. The fast pace of organisational change in the NHS meant that many Trusts changed their names and boundaries during the time period.

Thus it was a long and drawn-out process that involved me contacting twelve NHS Trusts in England to ask for R&D approval for the study. All the Trusts I applied to did eventually give their approval, though some required me to provide additional documents or undertake tasks that my CLRN considered unnecessary. A pack of documents (see Appendices 1, 2, 3 and 4), with all the information that had to be made available to the participants, prescribed by the CLRN, was supplied. Once approved the NHS Trusts

provided letters of approval for my study to proceed and for access to NHS sites. I then was in a position to contact potential participants.

I would very much have preferred not to have to contact my participants through the NHS process but as I wished to confine my sample to art therapists who were employed by the NHS I was advised that there was no option. However, the procedure imposed a number of differences to my research approach that I was required to adopt, particularly the method for contacting participants, which I could have done efficiently and in a timely manner through my professional networks. The literature which was to be given to participants had to follow a prescribed format and thereby changed what I would have provided as well.

Sample

I adopted a purposive and homogeneous sampling strategy (Esterberg, 2002), as I aimed to recruit art therapists who worked in the NHS with people who had learning disabilities. I was aware that qualitative sampling might involve small numbers of participants while generating large amounts of data (Fossey et al, 2002), though Moustakas (1990) recommended ten to fifteen participants.

It was too difficult to try to recruit art therapists who worked with people with severe learning disabilities and challenging behaviour as there were only twelve NHS Trusts I could recruit from; however, I was able to recruit fifteen art therapists willing to participate.

My criteria was that they should have been qualified and worked for the NHS with people who have learning disabilities for a minimum of one year, as less than this amount of experience seemed insufficient for participants to be able to contribute appropriate data to this study. Participants were able to withdraw from the study at any stage in the process.

Recruitment of Participants

Once R&D approval was granted, potential interviewees were identified by their organisations and then all possible participants to the study were invited by email. Although I gained R&D approval from twelve NHS Trusts I was only able to recruit from eight, as no art therapists were contactable at the other four.

Once the art therapists I contacted responded indicating their willingness to participate in the research, which all did, I sent a second email with the document pack to each potential participant. The pack included an invitation letter (Appendix 1), the participant information sheet (Appendix 2), the interview schedule (Appendix 3) and a consent form (Appendix 4). After the information had been read participants emailed me back agreeing to participate in an interview. The art therapists I recruited worked in teams of different sizes, some had regular contact with each other, while others did not have contact with colleagues in the same Trust due to the size of the organisation; two of the art therapists talked to colleagues about the research and contacted me to let me know they were willing to participate in their second email, and three participants were recruited in this way.

Once all participants had read the documents I sent a third email to make arrangements for venues, dates and times. Five interviews were arranged by the fourth email I sent out, confirming arrangements, and eight of the other ten required a fifth email; the remaining two required a phone call, which was followed up by a (fifth) email.

I found it difficult to involve the participants in the process as closely as I would have liked and Moustakas (1990) recommends, due to the fact that I was working full-time as well as studying, however I involved them at three stages during the process: 1) to check their transcripts, agree any data they wished to exclude, and clarify queries; 2) to read the Findings Chapter when finished and agree to the inclusion of their verbatim quotations, 3) to provide feedback on the Findings Chapter as a whole. For this reason I was advised not to refer to the art therapists as co-researchers but as participants.

Interview Sites

The interviews were conducted in venues decided between researcher and each participant, at their place of work, at eleven NHS sites across England during a period of four months, a total of 1,622 miles travelled. Two interviews were conducted in different areas of London, seven in the North of England, one in the Midlands, and five in areas south of London.

The locations for the interviews were the art therapist's office (four participants), an art therapy studio (six participants) or a consulting room (five participants), on an NHS site. This meant that I was not in control over the environment in which the interview was conducted, although each participant took care to ensure that the room was as quiet and

uninterrupted as possible. The lone worker procedure of my NHS Trust was adhered to during the course of the interviews; some adverse weather conditions were encountered during one of the trips across England when a heavy snowfall somewhat affected the journey, but did not prevent the interviews taking place.

Anonymity

In order to anonymise the data and preserve confidentiality the participants were invited to decide on a pseudonym that was used when they were referred to in the course of the data analysis and the thesis. Care was also taken to reduce details that might identify the participants or their colleagues, clients, teams or locations, and participants were able to request parts were excluded for the same purpose.

Informed Consent

Gaining consent from the participants was straightforward as anticipated, because of their voluntary participation; in addition, they were provided with information about their role in the research and what they were required to consent to prior to signing the consent form at the interview and initialling the tick boxes. The Consent Form was signed by each participant and me (see Appendix 4) and sought:

- 1) agreement that the participant had read the participant information and had the opportunity to ask questions
- 2) agreement that the participant's participation was voluntary and could be withdrawn at any time until included in the final version of the thesis without giving a reason
- 3) agreement to be interviewed and for the interview to be recorded on a digital voice recorder
- 4) agreement to anonymisation of the data to protect participants through use of a chosen pseudonym, which was specified on the form
- 5) agreement about the storage of data as detailed in the participant information sheet
- 6) agreement to take receipt of the transcript and comment on it within two weeks, and similarly to feedback on other aspects of the data such as the Findings Chapter, retaining the right to withdraw parts until included in the thesis
- 7) agreement to the raw data being seen by my supervisors as part of the analysis
- 8) agreement to the inclusion of data in the thesis post-analysis and in subsequent publications

Participant Information

A Participant Information Sheet (Appendix 2) was provided prior to participants agreeing to participate, adhering to the requirements for NHS R&D approval.

It covered the following areas: the study's title, my identity as researcher and the purpose of the research; brief details of the research design, ethical approval granted and by whom, and who to contact in the event of a problem; advice if the participant felt upset by the interview, the voluntary nature of the participant's involvement and the right to withdraw; what participation entailed and possible disadvantages and benefits of taking part; storage of data, insurance/indemnity by the university, thanks for agreement to participate and my contact details. Participants were advised that any problems or complaints that might arise would be dealt with promptly; any concerns that needed to be addressed by someone with greater authority could be addressed to the academic supervisor, and contact details were provided.

Storage of Data

Identifying information, such as the participants' names and pseudonyms, contact and job details were known only to myself and were stored on a password-protected memory stick locked in a filing cabinet at my place of work. This identifying data is to be stored for ten years after the end of the study and then destroyed. No information about participants, other than that which they supplied, was sought from anyone else.

All electronic research data, such as interview transcripts, approval letters from NHS Trusts and research logs, were stored on a separate hard drive, password-protected, which was locked in a filing cabinet at my workplace, as were paper copies; all research data are to be destroyed a maximum of ten years after the study has ended.

Benefits and Disadvantages

Many of the participants felt they benefited from the opportunity to discuss their issues concerning the impact of the work on them and how they coped, and several art therapists reported that participation resulted in them changing their attention to their self-care and a consequent improvement in how they felt and functioned professionally. Art therapists who were interested in undertaking research themselves may have found that participating gave them a better idea of what is involved, and participation counted towards their continuing professional development.

I believe the study will be of benefit to the art therapy profession, in promoting longevity and attention to self-care for art therapists, which is a subject little explored in the literature, and to NHS managers who may gain awareness of stressors for art therapists and other healthcare workers, and appropriate management of occupational stress. The benefits to me were many, including learning how to interview effectively, meeting art therapists within my field, gaining the benefit of multiple viewpoints, gathering the data for my PhD, contributing to my own wellbeing, and learning to write for publication.

There appeared to be no disadvantages for the participants. Disadvantages for me, the researcher, were experienced in terms of the time commitment, distances travelled, adverse weather conditions, costs borne and lone worker issues, however the disadvantages were outweighed by the benefits.

The Right to Withdraw

Participants could withdraw from the study at any time without repercussion. When the transcripts of the interview recordings were sent to participants they had the right to withdraw parts of the interview they did not wish to be included for confidentiality purposes, which three did. Once the research data was analysed participants had an opportunity to withdraw parts of the data from the Findings Chapter until included in the final version of the thesis, and two participants requested that finer points relating to them were made less obvious to protect their identity.

Interviews

The interviewing method used was a form of narrative similar to conversation, undertaken in a reflexive manner, which included disclosure where appropriate, and sensitive responses to the narrative as it unfolded in a manner akin to a therapy session (Moustakas, 1990b; Chwalisz et al, 2008; McLeod, 2001). The skills I developed as an art therapist were compatible with heuristic enquiry and were those needed for interviewing participants with sensitivity (Gilroy, 2006; Etherington, 2004b). I started with the research questions and a brief explanation of the purpose of the interview, and the interview style allowed the interviews to be free-flowing (Esterberg, 2002); I viewed it as a co-production, or construction, between researcher and participant that accessed complex and sensitive material (Mason, 2002; Gilroy, 2006).



Figure 3: 'Mind Maps', March 2010

The Consent Form was discussed with the participant prior to commencement of the interview, and both parties signed them and retained a copy; the participant was invited to decide on a pseudonym by which their data was referred to protect their anonymity. The participants' right to withdraw was made clear, as were arrangements for storage of personal details and data, and inclusion of the data in the PhD thesis and subsequent publications. Any further queries the art therapists had were also addressed.

The interviews lasted between one and two hours, and took place at a venue mutually convenient to participant and researcher; a digital voice recorder was used to record the interview. After the Consent Form was signed, a brief outline of my interest in the research topic was given, and the main research question 'what is the impact on you of working in the NHS with people who have learning disabilities?' was asked. Six questions were held in mind, though others arose naturally as the interview progressed (see Appendix 3):

1. Can you tell me about your experience of stress arising from your work as an art therapist working with people with learning disabilities?

2. Can you tell me what you find positive and satisfying about your work as an art therapist working with people with learning disabilities?
3. Can you tell me about your experience of stress arising from your experiences as an employee of the NHS?
4. Can you tell me what you find positive and satisfying about your experiences as an employee of the NHS?
5. Can you tell me about how these issues impact your work/life balance?
6. Can you tell me about your approach to self-care?

When the interview concluded I checked how the participant was feeling and we debriefed. Finally, I thanked the participant and made arrangements to send them the transcript for feedback when I was able to. After leaving the interview venue field notes about the context and my experience of the interview were made, which formed another source of data. Having made the interview schedule available prior to the interview meant the participants thought about how they would respond, which they indicated had been helpful to them.

1.4 Introduction to the Participants

I recruited fifteen participants, all employed as art therapists within NHS Trusts and learning disability services. Their experience ranged from three years post-qualification to over twenty years, and their status from locum to head art therapist; thus they embraced the full range of relevant experience for the purposes of my study. I will now introduce the participants:

Maria had been working in the same NHS Trust for over twenty-five years. She was employed as an art therapist four days a week in two posts, working in mental health and learning disability services, and usually had a trainee on placement with her. Maria had one art therapist colleague and worked within a psychological services team, within the wider context of a community learning disability team. On a personal level Maria had recently experienced a relationship breakdown and was in the process of divorce; she had become, therefore, a single parent, however she had started a new relationship she was hopeful about. Maria had experienced serious health issues in recent years, and had responsibilities as the only child of an elderly parent. At the time of the interview Maria had just lost an area of practice in her post that she was very upset about, and restructuring was being discussed with much uncertainty about what it would look like.

Stacey was married, and had been qualified for three years. At the time of the interview she was working as a locum art therapist for three days a week in an arts therapies team, within an NHS community learning disability team that had been through a lot of change. The service had become a Social Enterprise and introduced hot-desking but did not provide any mobile IT equipment; the Trust had also introduced room sharing and she had to transport art materials and client artwork to different venues. This was Stacey's second locum position with this Trust, and she was due to take up a permanent art therapy post in a nearby area shortly. In addition to her locum post she also had a permanent art therapy post one day a week in an acute learning disability NHS setting, and sessional work on another day.

Walter was married with two small children, had been qualified for six years, and worked full-time in two art therapy posts in a large NHS Trust. Despite much uncertainty about whether his posts would be safe, he was happy to have survived a recent major restructure in his Trust. He worked with children two days a week, and with people with learning disabilities three days a week, and was based on two sites. He was a member of an arts therapies team, who had retained their rooms; administration tasks and driving had increased as a result of the agile working policy, though he was provided with mobile equipment. He found the work with children's services far more onerous than his learning disability work.

Stephen worked full-time as the only art therapist in a learning disabilities service for a large expanding NHS Foundation Trust. He had become a lone practitioner when his colleague left and her post was lost, and also lost his team and his art room; to compensate Stephen joined a psychology team. He had negotiated and re-invented his professional identity and the boundaries of his role during the past eighteen months. This had entailed a substantial change in his working practice, including twice as much driving, sourcing rooms for sessions, and transporting art materials. Stephen was married with two children. The family had been living with relatives in temporary accommodation for a year, but expected to move into permanent accommodation shortly; this was part of a strategic plan to move to a new house in the centre of the expanded geographical area Stephen was now expected to cover. He had a health concern that he had become aware of, which he attributed to occupational stress.

Jayne had been qualified for sixteen years, was in a long-term relationship and had two children. Jayne was the only art therapist working full-time across two teams in a learning disability service with children and adolescents, which she had done since qualifying, in the same NHS Trust. Jayne was a placement supervisor. Driving had increased and Jayne visited nine therapy venues in schools during the week; hot-desking had been introduced in her Trust, but she also had agile working equipment, which she found helpful. Jayne enjoyed her personal image making but would have liked more time for it. She had a background of childhood trauma which made her prone to depression from time to time, although she was self-aware and worked to manage this aspect of her life.

Sarah had also been qualified as an art therapist for sixteen years and had worked in the Trust for thirteen years within learning disability services, with experience of different roles during that time. She was married with two children, and moved to her current role in a new integrated inpatient service for children and adolescents about eighteen months previously; she worked part-time (eighteen hours) flexibly - to fit in with the service and with her domestic life, which aided her work-life balance. In her current role she worked with children who had learning disabilities as well as those who did not; Sarah was a member of an arts therapies team and a supervisor. Sarah experienced some financial strain and her elderly parents had health issues.

Simon had been qualified for six years and worked in a large NHS Trust for five; he was married. Having originally been part-time he was now a full-time permanent member of an arts therapies team within a community learning disabilities team that had become a social enterprise during a substantial reorganisation within the Trust. The team had lost its manager and senior practitioners due to down-banding, which resulted in Simon having to step up to managerial roles when necessary; hot-desking had also been introduced but no mobile equipment. He was experiencing some stress in his personal life, which impacted his personal art practice.

Katie had three part-time posts, one in an inpatient forensic learning disability service for two-and-a-half days a week and had been in post for three years. She had another two days in a youth offending team, and also worked half a day for one of the art therapy training courses. Katie was married and expecting her first child, and was going on maternity leave a few weeks after the interview. She did not discuss any issues as a result of organisational restructuring during the interview, and was the only participant who did

not; she was also the only art therapist working full-time in multiple roles who did not find that stressful. She maintained her art practice and had studied for a Master's degree.

Andy was a Head Art Therapist of an arts therapies team in a learning disability service that had gone through a major restructure in the past year within a large NHS Trust. To his and the other arts therapists' relief they had retained their posts, a budget and their rooms. He was married with three children, and had worked full-time in the Trust for nine years. During this time he had worked hard to de-mystify art therapy in the Trust, reduce tensions in the team, and enable a unified, effective and happy team to emerge. Andy had been working with people with learning disabilities for upwards of fifteen years, and worked mainly in low and medium secure forensic inpatient settings. He had recently completed a PhD.

Dan was married with one young child, and worked in a child and adolescent learning disability service for three days a week. He had qualified three years earlier, and had ten years' experience of working with people with learning disabilities. Only twenty percent of Dan's current post was for art therapy and the greater proportion of his post was more general learning disability work with children, their parents and the systems in which they were situated. He was a member of a psychology team that was greatly depleted due to team members being on secondment and maternity leave. He combined caring for his child two days a week with his post, however at the time of the interview his wife had just suffered a third miscarriage.

Ruby had been qualified for over twenty years, and for fourteen years had worked three days a week as the only art therapist in a large community learning disability team that had been under threat of a forty-six percent cut for some time. Members of the team including Ruby felt this would result in their service not being viable, and possible loss of posts; she had been struggling for some time with the uncertainty this created. Ruby had also been very stressed over the past eighteen months by having to co-ordinate a funding bid for a client she worked with, normally the role of social services, which had gone on for months and was completely out of her art therapy remit; as a result she was concerned about burning out. Ruby had also experienced a recent relationship breakdown and had financial concerns, but was developing a private practice and painted on a regular basis.

Jill was single and had been working in the same NHS Trust since she qualified eighteen years ago. She was a Strategic Lead (reporting to the Trust Board), with responsibility for six arts therapists, but her post was due to change from strategic to professional lead, which she was optimistic would give her more authority to act – she had two therapists on long-term sick who needed help and were stretching the team’s resources. Jill had moved between teams to reduce her travel, and had pulled back from some activities such as study and research to spend more time with her elderly parents, one of whom had significant health concerns.

Joan was in a long-term relationship and had two young children. She worked in an adult learning disability service three days a week, having reduced her hours from full-time; a second art therapy post was frozen, making her a lone practitioner and solely responsible for a growing waiting list, which she had struggled to reduce though she had experienced some success. There was much uncertainty about restructuring in her Trust, which was made planning hard, though she had been told her post was safe. Shortly after the birth of her second child Joan experienced a sudden close family bereavement and was still in the grieving process when I interviewed her; in addition, her younger child had health difficulties requiring hospital admissions.

Rae was divorced with three teenage children, and had been qualified for over twenty years. She worked three days a week in a forensic medium secure inpatient learning disability service, having developed a new art therapy service, and she managed a team. It was her first experience of learning disability work, having worked with adolescents with special needs before. She had also pioneered two new services and had a private practice. Personally, Rae had experienced a number of traumatic events in recent years, including having been made redundant, and had health issues. She frequently worked overtime alongside other Head art therapists as there were many issues as a result of restructuring in their Trust, and they were unsure how safe their jobs were.

Lucy had been working with people with learning disabilities for fifteen years, part of an integrated multi-disciplinary team within the learning disability service of a large NHS Trust, but also managed within social services. She was also part of an arts therapies team. Lucy worked seventeen hours across three days and combined this with a private psychotherapy practice, having undergone the training some years previously. The knowledge gained had changed her practice and she engaged in collaborative work

assisting struggling client placements, alongside her art therapy practice with individuals. She valued being able to paint outdoors.

I am grateful to the fifteen participant art therapists for their willingness to engage in this process with me.

1.5 My Research Journey

Journey of Discovery

The experience described in the Autobiographical Chapter (Chapter Three) led to me undertaking this investigation into the impact of the work for art therapists working with people with learning disabilities in the NHS. It was a hard experience to process, firstly because of the interplay of three aspects of experience running side-by-side - my older adults post, my LD post and my personal life. Secondly because of the emotional and psychological impact of the experience on me, and the time it took to gain enough distance to be able to address it with a sufficiently absorbent and analytical frame of mind, and to express that appropriately. Thirdly the research journey was difficult, lengthy and complex, and I was in danger of running aground during the process. Fourthly, the process of analysis was very messy, and although that is well documented as normal in the research process (West, 2013) it worked alongside the impact of working with LD clients on my thinking processes. Periods of job insecurity and uncertainty at work also impacted me, and these issues resulted in a tendency towards negative bias which I struggled to overcome.

During my initial period of engagement with the subject of my PhD I spent some time working on the shape of research that I intended to undertake, and wrote a number of papers exploring the research from different angles until I became sure of the direction I was to take. The heuristic methodology seemed very appropriate for the journey I was to undertake, and I conducted a number of self-dialogues as I immersed myself in the process of the methodology that Moustakas (1990, 1985) described. Self-search is a process that is integral to the heuristic approach and involves a dialogue between selves, similar to a therapy or supervision session, and thus a process that feels quite natural for an art therapist.

Conducting such a process during a period of concentrated immersion in material relevant to the investigation is quite intense and draining. A period of ‘incubation’ afterwards,

during which one withdraws from the immersion for a time can be something of a relief during which one can recuperate for a time and engage in some ‘normal life’. Generally this results in ‘illumination’ where the two previous processes coalesce into an understanding previously hidden. I found this process entirely natural, and that I went through cycles of immersion-incubation-illumination over varying periods of time. Sometimes they were mini cycles over days and sometimes much longer, over months.

As I wrote the Autobiographical Chapter I engaged in further self-dialogues to help me think about the material from a different perspective; a considerable volume of material was produced during these processes and I chose to include three that seemed most pertinent for the chapter.

I found that the self-search process itself sometimes resulted in ‘illumination’, and revealed some unexpected understanding, which occasionally was disturbing, but I found it a really beneficial technique. I used the self-search process when I was stuck sometimes, as well as spiritual and creative approaches, which included prayer, mind-maps, art journaling, and image-making focused on aspects of my process or material which helped me to assimilate aspects I was struggling with.

The PhD process of producing a literature review and half the thesis for upgrade somewhat took the heuristic process off track for a time, but the NHS process of ethical approval for research undertaken with NHS staff (IRAS) compounded my difficulties. Going through the NHS ethics procedure was an onerous task and took far too long – I did try to avoid the process but could not have taken the NHS and organisational aspects of the impact on the art therapist into sufficient account had I circumvented it. Therefore I decided that to engage with it was necessary, however I found it quite stressful.

Process of Analysis

When I began my analysis of the data I had doubts about my capacity to use the heuristic process, which is very demanding (Patton, 1990). During this period, influenced by psychologists I worked with, I tried applying Interpretative Phenomenological Analysis processes (Gee, 2011; Eatough & Smith, 2008; Larkin, Watts and Clifton, 2006; Shinebourne, 2011; Smith, Flowers and Larkin, 2009; Smith, 1996; Smith, 2004; Smith, 2007) to analyse my data over a concentrated period of time, hoping this approach would feel more supportive and guided. However I found I could not engage with the process,

despite it being entirely appropriate for my study, the reasons for which I could not articulate, and I struggled with negative bias, which my PhD supervisors drew attention to. Eventually, somewhat frustrated, I returned to the heuristic process and did a self-search about the negative bias (see Appendix 5), but continued to struggle with the lone journey I had harnessed myself to.

The Autobiographical Chapter had a long journey in its conception, having completely changed from the account presented in my upgrade material to the one I present in this thesis, going through four painful stages before a period of spiritual and creative renewal seemed to result in a chapter that hung together as it needed to. I was heartily relieved



Figure 4: 'Endless Paper', October 2010

when I overcame the barrier I had experienced before, however this long process was repeated with other chapters. I searched through my clinical process notes, my supervision notes, and my journals of that period of time. I spent considerable time finding appropriate journal entries for this chapter, and was glad I had kept journals for so many years.

The Findings Chapter was just as difficult to write, and to think about analytically as I had spent over fifteen years working with people who could only think concretely, and this caused me many difficulties. The data analysis was complex and I struggled to think

about how to organise the datasets, which felt huge and unmanageable for some time. Eventually I gained more emotional distance and was able to take a meta-analytical position with the data rather than stay in the descriptive and concrete.

Once the Findings Chapter had been analysed I went back to my own data in the Autobiographical Chapter, in which I was able to see similar patterns and speak to the data in that way. The rest of the thesis came together when I was able to address it as a whole, enabling me to write the Discussion and Conclusion, and add the other details that made the thesis up.

Meanwhile Normal Life Continued

During the years in which I have been working on this research project many significant life events have taken place, which had a considerable impact on me - character-building in some cases, lovely or difficult. They included my father's death, separation following the trauma of domestic violence and subsequent divorce, and moving house three times. My children finished school and left home, I supported them through university education and two have married. I was fortunate to be supported by successive managers at work with study leave, but was responsible for my own expenses; at the same time I was subject to job insecurity at times, many changes in the working environment and changes in my roles within the organisation. Inevitably some of these events slowed the research process, as I had to take time out, however such periods also gave me 'incubation' time in which the unconscious processes Moustakas (1990) discussed took place. I worked full-time during most of the course of my study, which placed considerable pressures on me, although my LD managers were particularly supportive, as was my clinical supervisor.

Impact of my Work on Me

Another issue, mentioned in the Autobiographical Chapter, was the impact of my work with people with learning disabilities, and in my other role, dementia, on my thinking processes, which were handicapped at times by the attack on thinking I experienced (Ashby, 2012, 2014a). As an art therapist working with people with learning disability I was subject to the same emotional and psychological experiences as described by my participants, particularly impacting my thinking, my sense of being deskilled, marginalised and of hopelessness, which left its mark in terms of negative bias that I was

made aware of by my PhD supervisors who were my auditors (Reay, 1996; McLaughlin, 2003).

My own experience of organisational restructuring within the NHS became more anxiety-provoking during the process of the research and was another source of negative bias that my PhD supervisors had to remind me to be mindful of throughout the process of analysis. Periods of incubation following immersion assisted me to re-align my thinking, but this was a pitfall I had to be mindful of during the whole process.

1.6 Data Analysis

Thematic Analysis

As mentioned earlier, I had doubts about the analysis stage of the heuristic process and explored using Interpretative Phenomenological Analysis (IPA), but this proved to be something of a red herring and took some time. I then turned to Thematic Analysis as a method that would enable me to manage all of the data and would work with the heuristic process (West, 2013).

Thematic Analysis is a flexible approach that is accessible, can be used across different theoretical frameworks and potentially can enable researchers to record rich, detailed and complex data, however it also one that has not been given clear guidelines (Braun and Clarke, 2006; Vaismoradi et al, 2013). Thematic Analysis involves a painstaking process of moving between individual transcripts and the entire data set and carefully searching for patterns of meaning (Patton, 1990). Manifest content of the data can be understood in terms of latent meaning, and both inductive and deductive processes are possible with this method (Joffe and Yardley, 2004), which is described in some detail by Braun and Clarke (2006).

Participant Portraits

Individual portraits of each participant were created from their interview and feedback data relating to their experience of the phenomenon (Moustakas, 1990; Start, 2008), which enabled me to hold the group of participants in mind during the process of analysis. These depictions formed the basis of the introduction to each participant in this chapter and may be seen in Appendix 6.

Transcripts

I transcribed the interviews from the voice recordings myself to gain familiarity with the data as I became immersed in it (Etherington, 2004b; Patton, 1990), although this process required a considerable time commitment and took longer than anticipated. To ensure participants' confidentiality each transcript referred to the participant by their pseudonym and was checked by them before analysis began.

The transcripts were typed in conversational style, as in a play, each person's contribution following on from the previous utterance, with hesitations, laughter and other utterances noted in square brackets. This format made the transcripts easy to read and showed what part I played in the construction of the conversation, adding to the rigour of the data analysis (Etherington, 2004b).

Once all the transcripts had been checked by the participants I began to process the verbatim data. After several false starts, documents were created with three columns, one for the transcript chunked into roughly themed sections (which made the data easier to work with), another for themes, and a third for a short summary of each different part of the discussion and its reference. As each transcript was worked through and the process of immersion was in full force a greater sense of the data as a whole was gained, but I needed to consciously, on some level, avoid losing sight of the whole dataset while immersed with each individual participants' experience.

Once all the transcripts had undergone a process of extracting the themes I encountered a difficulty creating a format that enabled the whole dataset to be seen easily, due to the quantity of data produced during this process. Summaries and mind maps were produced which assisted in reducing the amount of data I was working with, and enabled the themes and sub-themes for each participant to be extracted. This enabled easier comparison, and created different levels of organisation of the data. Then all participants' themes were laid out in three sections that related to context, person and impact; this latter format worked best and aided further comparison between datasets. This process resulted in overarching themes and sub-themes of the overarching themes being identified.

As the findings were written up for the thesis, Chapter Four, I returned to the detail of the transcripts to enable retention of the language of participants by including verbatim quotations and including examples of experiences described; in this way I ensured that

the participants' voices could be heard in the analysis (Stephenson and Loewenthal, 2006). Several attempts at writing the chapter were made, each of which had to be significantly revised, before I reached a format that worked.

Member Checking

The participants engaged in a process of checking the transcripts to ensure that the data collected reflected their views as fully as possible (Fossey et al, 2002; Moustakas, 1990; Slevin and Sines, 1999/2000) confirming the reciprocal nature of the research relationship (Gilroy, 2006). When the transcript was sent to each participant queries were clarified and three participants requested deletion of parts they did not wish to be included. After I had analysed the findings I sent a copy of my report to each participant for feedback and requested permission for direct quotations that I wished to include in the report of the findings, and two participants requested changes for confidentiality purposes. I was also required to send a copy of my report to the NHS Trusts in which I had conducted my interviews.

Immersion, Incubation and Illumination

The process of immersion, involving repeated reading and re-reading of the data emerging from the interview transcripts and field notes as they were typed up and as the data was organised, which enabled deep engagement with the research material; the holistic perspective of immersion is a form of rigorous discipline (Patton, 1990). Periods of incubation, during which I took a break from the immersion, allowed the tacit dimension time to process the information from the data on an unconscious level, and as a result clusters, sub-themes and overarching themes emerged and could be identified (Patton, 1990; Stephenson and Loewenthal, 2006). The process and quantity of material gathered was extremely time-consuming and confusing to work through, yet interesting and encouraging as greater understanding was gained and ways of organising it were found (McLeod, 2001).

New meanings emerged from the data after periods of immersion and incubation resulting in 'illumination' as it was grappled with. Multiple cycles of immersion, incubation and illumination took place during the period of analysis, and at times there was a considerable struggle to find a way of organising the data that enabled the parts to be seen as a whole as I gathered together all the data in all its different forms.

Explication

The writing of the formal analysis began to take shape during the explication phase which followed, and was a period of deep reflexivity on the process (Nuttall, 2006), resulting in the Findings Chapter, and then the Discussion Chapter, which drew the themes and experiences together (Start, 2008). Once all the elements of the individual datasets had been brought together in this way the chapters were checked by my supervisors and the participants and altered as necessary. As previously noted, feedback from my academic supervisors formed an important and integral part of the iterative process during the writing up period.

The final phase of the analytic process was the production of the Research Report, in the form of the PhD thesis, which concluded the research process. The thesis will be followed by articles prepared for publication in professional journals, and presentations to conferences and groups of art therapists such as the Art Therapy and Learning Disability Special Interest Group, and the Art Therapists Practice Research Network.

Composite Depiction

A Composite Depiction of the art therapists was created from the findings, which follows Chapter Four, and is a synthesis of the findings that can be applied to me and each of the participants in some way.

Creative Synthesis

As a Creative Synthesis of the research, in addition to the thesis and images, I produced a poem entitled 'Saving Howard' on an image of a 'quilt', which speaks of thanks and issues related to the thesis, as if spoken to Howard, my colleague who burnt out. This can be found on page 247.

1.7 Data Sources

In order to establish methodological rigour through triangulation of data (Patton, 1990; Mason, 2002; Fossey et al, 2002; Slevin and Sines, 1999/2000), several sources of data were accessed during the data collection and analysis periods. Ultimately these resulted in the Composite Depiction, production of the PhD thesis as the product of the Explication

process, and the poem for Howard as the Creative Synthesis. These processes are integral to the heuristic approach (Moustakas, 1990; Start, 2008).

Data sources included a Research Journal, work notebooks and personal journals, and self-searches. There were also images and mind maps that were created, the interview transcripts, and feedback received from participants and from my supervisors.

The Research Journal was used to document the process of the study and provide an audit trail; it incorporated field notes gathered at interview sites and my responses, thoughts and interpretations of aspects of the research process, and the development of my thinking during the process. Reflexive journals enable researchers to keep a coherent narrative of their research journey and can capture the process of change as different aspects of the study emerge and develop; a growing self-awareness in this way can facilitate recognition of bias and provide a way of working through stuck periods (Etherington, 2004). It is also consistent with the heuristic self-search process. An example from the journal is provided on page 64.

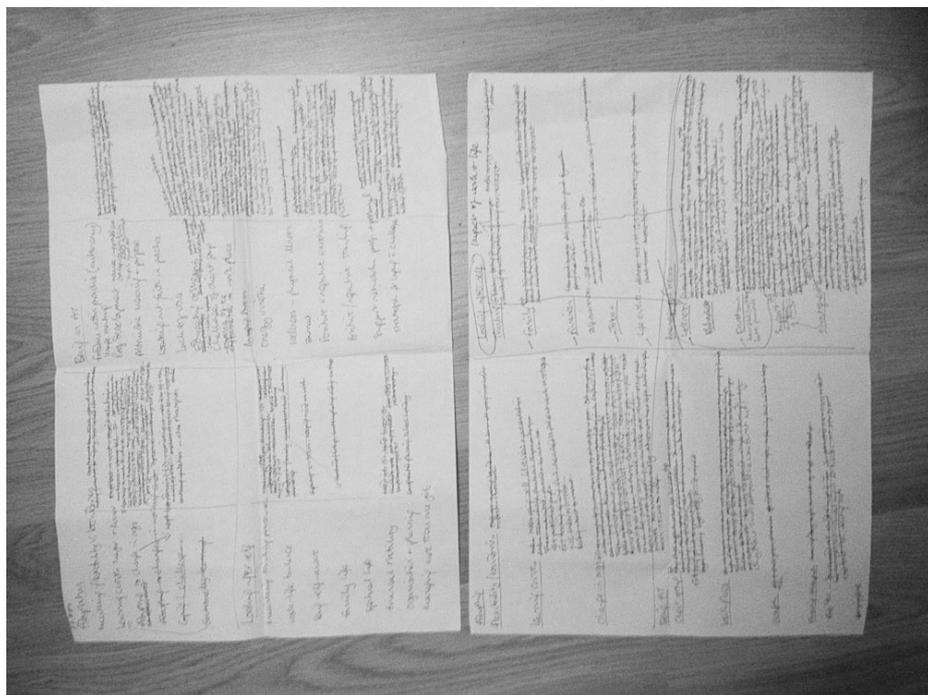


Fig. 5: 'Process of Discovering Emerging Themes', January 2012

Work and personal sources of data included clinical notes and journal entries that were used to facilitate and record my experiences in the Autobiographical Chapter. During the process of the PhD study I created many images and mind maps, which assisted my

thinking. Image-making is integral to art therapists' methods of reflecting on and processing material (Gilroy, 2006; Moon, 2002; Mahony, 2010; Kapitan, 2010) and to Moustakas's (1990) method, as he advocated inclusion of creative sources of data, such as images, poems and stories. A number of the images are included in the thesis.

Voice recordings of the interviews and their transcripts, which were produced in paper and electronic versions, were the major sources of data from the participants, and were consulted over and over again.

1.8 Issues Addressed in the Research Process

Validity

Issues of validity were addressed by ensuring that the themes and sub-themes vividly and accurately depicted the meanings of the participants' experiences, and that these were recognisable by the participants and readers, thus achieving 'fit' or coherence (Moustakas, 1990) and demonstrating the trustworthiness of the research findings. The data was subjected to rigorous checks to ensure that the understanding and meanings described rang true and demonstrated internal consistency.

Feedback from participants provided testimonial validity (see Appendix 7), and feedback from my academic supervisors, and from my clinical supervisor at work, during the process of analysis also established credibility through the use of triangulation. The process provided a method for highlighting areas that might have been overlooked, enabling me to go back and check the data and further investigate these aspects before incorporating them into the final report.

The clarity of the report of the analysis of the data and the findings contributed to its credibility. Showing how my thinking was changed by the research process and the data demonstrated reflexive validity and permeability, and enabled readers to situate me as researcher within the study; this increased the legitimacy of the findings (Sword, 1999). Verbatim data from interview transcripts in the form of direct quotations are included in the research report ensuring that my and the participants' voices can be heard, and the findings were grounded in time and context. An audit trail was provided that clearly shows the process of the research, ensuring findings were grounded in data and were sufficiently useful, which established confirmability.

Lastly catalytic validity was achieved through the degree to which the research process positively affected or empowered participants (Chwalisz et al, 2008), which they confirmed was the case. Validations in the form of responses from participants and other readers were encouraging and revealed the extent to which the research ‘hit the nail on the head’ (see Appendix 7). Moustakas received over 1,000 letters of validation in response to the publication of his book about loneliness (Moustakas, 1990, 1961/1989).

Insider and Outsider Research

Heuristic research, in addition to being inherently reflexive, also has an ‘insider’ aspect, since the participants recruited to a heuristic study are people who have experienced the same issues as the researcher in relation to the phenomenon being investigated, but are not necessarily members of a particular group. I was an insider as an art therapist interviewing art therapists, but an outsider as the researcher and an art therapist from a different area, organisation and team.

Rooney (2005) suggests that ‘from an anti-positivist perspective... insider research has the potential to increase validity due to the added richness, honesty, fidelity and authenticity of the information acquired’ (p.7). The dual aspects of being insider and outsider can greatly aid the construction of a contextual understanding of the phenomenon under investigation (Fossey et al, 2002). Insider researchers find there is less of a power imbalance between researcher and participant.

There are benefits to insider or practitioner research such as mine, but there are also some drawbacks (Edwards, 2002; Fossey et al, 2002; Robson, 2002), as I found. Common understandings between my participants and myself did enhance interaction in the interviews and meant that I was able to follow up lines of enquiry that I might otherwise have been unable to. However afterwards I found that in a few cases familiarity with the issues resulted in assumptions being made by participants that I failed to follow up at the time, and later this caused difficulty understanding their meaning (Kanuha, 2000).

My insider status did make my art therapist participants more at ease and inclined to be open in the interviews, however Reay (1996) warned that it is possible that researchers may misrepresent or miss important information due to loyalties, political views and for other reasons. Therefore, the feedback from participants and auditors was important in ensuring the validity of my findings.

Voice

Qualitative research is best expressed vividly, in the voice of the researcher and in the first person, rather than in formulaic or scientific ways of writing (Esterberg, 2002). Writing reflexively enables the participants' voices to be heard and to be distinguished from that of the researcher, contributing to rigour; this provides evidence that the participants have been listened to, and of the researcher's permeability (Fossey et al, 2002). I have therefore reported the research process using the first person, and in my own voice, which is becoming common practice in qualitative research (Holliday, 2007), with participants' voices articulated as clearly as possible.

Gergen positions this as the Autobiographical Voice, in which the author attempts to share 'the 'lived experience' with the reader' as a 'personal self' (1997:163), reducing the distance between author and reader, and between author and participants. Autobiographic writing reveals the presence of the author's agency and their reflection on the participants' subjectivity; the constructed text also switches between the author's voice and participants' actual voices reported verbatim. Transparency and accessibility through the author's expression of experience is also inherent in this genre of inscription.

1.9 Ethical Issues

The ethical issues to be addressed were carefully considered in all aspects of the research process (ESRC, 2010). The procedures undertaken were necessary as a result of historical abuse of participants, resulting in considerable harm being perpetrated against people in the name of science, which must be protected against (Christians, 2003). Social science as a method of control of society was an issue Foucault (1979) raised, and I was aware of issues of power in the study as they related to my insider/outsider status.

Social ethics rest on complex views of moral judgements that must be made in the research process, assuming care for participants and resolving conflicts responsibly rather than just avoiding harm (Gilligan, 1982, 1983). Ethics are fundamental to human existence (Olthuis, 1997), and represent a wide-ranging philosophical debate (Christians, 2003). Procedural ethics concern research procedures, whereas situational ethics relate to issues that arise during the research process; relational ethics refer to connectedness between researcher and researched, and responsibilities towards intimate others who we may write about in our own stories (Ellis, 2007; West, 2013). I did attempt to consult my colleagues and gain their consent too.

Ethical Issues that Arose in the Planning of my Study

Arrangements for recruitment of the participants were subject to the NHS R&D process as discussed earlier in this chapter; the arrangements were primarily concerned with the welfare of the participants, but were to some extent inappropriate as the process assumed they were NHS patients rather than staff.

Many miles were travelled within England to interview the participants at sites that were unknown to me, but as Holliday (2007) points out, many researchers have to take opportunities that arise to conduct their research; in that sense researchers have to be opportunistic and work with what can be managed within timeframes and resources, though this can make research settings difficult to control. The participants did all make efforts to ensure quiet spaces without interruptions as these are normal conditions for conducting therapy, but it was not possible in all cases, and in three interviews there were interruptions. I was required to follow the lone working policy of the NHS Trust I work for during the course of my travels.

Participant confidentiality was addressed by inviting the participants to choose their own pseudonyms, as I was aware that some names might have bad associations for individuals. In order to protect them from unwanted exposure (Christians, 2003) participants were given adequate opportunities to veto any details they did not wish to be included.

One particular difficulty this research was subject to was the relatively small number of art therapists practising with people who have learning disabilities in the NHS, and some of the details participants revealed would be likely to identify them to some of their colleagues, should they read the thesis. In order to give participants every opportunity to ensure their confidentiality was protected to their satisfaction, as well as to ascertain the accuracy of the analysis from the participants' points of view, the Findings Chapter was sent to the participants for comments and permission to include verbatim quotes from each was requested.

The information given to the participants prior to the interviews had to be sufficient to enable them to give informed consent and to address possible risks (ESRC, 2010); it also had to satisfy the requirements of NHS R&D and therefore had to be presented in a prescribed format. The issues had to be carefully considered so that it was certain that the participants gave informed consent and participated voluntarily, and I was aware that

some complications could arise, such as when interviewees reveal information about third parties who have not given their consent (Mason, 2002). Related to these issues was the right to withdraw from the study that the participants had, without giving a reason or any repercussions (Esterberg, 2002) but chose not to exercise.

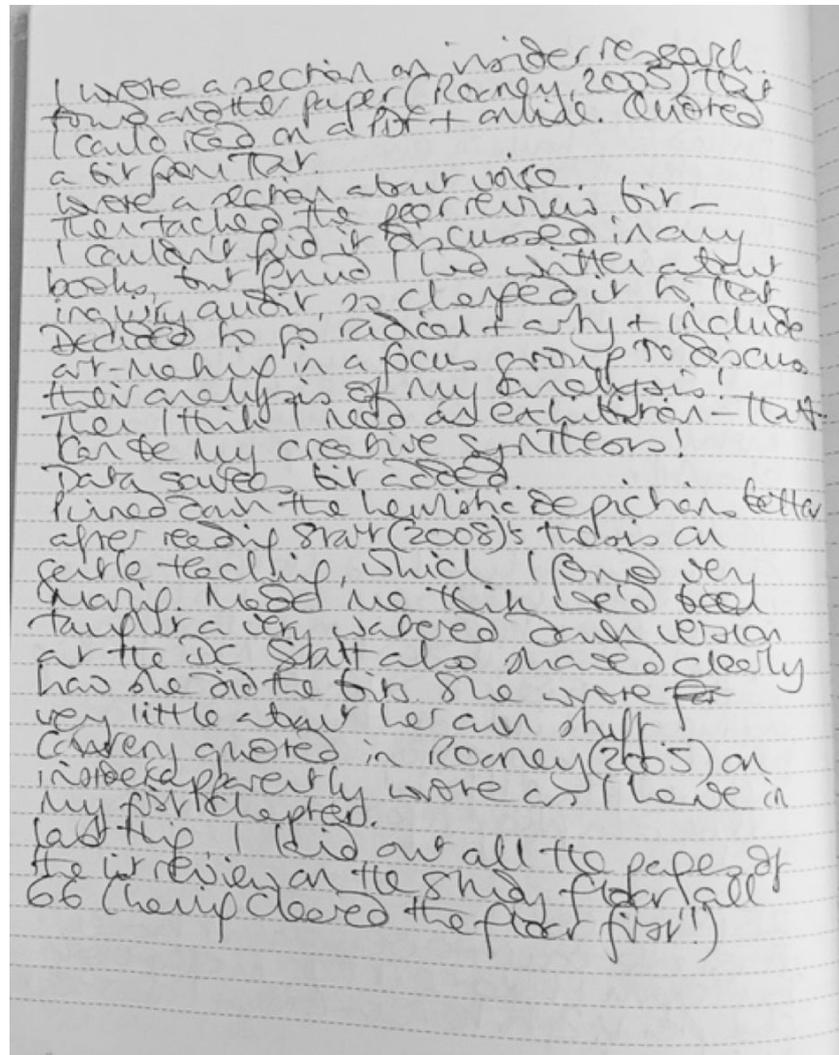


Figure 6: 'Example from Reflexive Journal', April 2012

Taking on board Gilligan's (1982, 1983) and Ellis's (2007) injunctions that avoiding harm for the participants meant care for them, I considered carefully whether they were likely to be harmed by the process. I concluded that they would not, as they participated voluntarily, were fully informed about what was expected of them, and had a connection with me through my insider status, as discussed earlier. In addition, the process was very straightforward. All participants, being art therapists, were extremely familiar with discussing their own issues in personal therapy, training and supervision. It was unlikely that discussing the issues in the research situation would have been difficult, but I took

the precaution of making provision should this arise (see Participant Information in Appendix 2).

This last point is particularly relevant to the autobiographical account in which my colleagues feature, which was addressed by using pseudonyms for them and consulting those I could contact. Where participants referred to colleagues or relatives this was addressed during the member-checking process.

The participants were involved in the member checking process described, which enabled them to remain part of the research process, production of the PhD thesis, and subsequent publications. Through this process I hoped to avoid the possibility that participants might feel uncomfortable reading the narrative relating to their experiences in print (Etherington, 2001).

Next

Chapter Two, which follows, positions the research within the relevant research literature, accessing important information about the issues addressed in the research project; the literature informed me of issues I would need to address during the research process.

Chapter Two

The Literature Review



2.0 Introduction

The Literature Review addresses the research questions, which are ‘what is the impact on art therapists of working with people with learning disabilities in the NHS?’ and ‘how have art therapists avoided burnout in their situations?’ The information explored in this chapter provides a background through which we can see how my experience of working with people with learning disabilities in the NHS, discussed in the next chapter (Chapter Three), and that of my participants discussed in Chapter Four, relate to the literature on the subject.

First, in Section 2.1, the Literature Review addresses the context of work by art therapists with people with learning disabilities in the NHS. Issues faced by people with learning disabilities in Britain are discussed first. Next the situation of the NHS and the pressures it, and its staff, experienced in recent years during constant cycles of change are addressed. Thirdly issues impacting art therapists and their practice in Britain are discussed.

The second part of the Literature Review, Section 2.2, focuses on what occupational stress is, how it impacts people and its causes; I also consider relevant theories of occupational stress and burnout. This section then addresses occupational stress and burnout research in relation to staff working with people with LD, NHS staff, and art(s) therapists. There is a considerable body of research literature on occupational stress, much of which is quantitative; I concentrated more on qualitative research, but where the research is limited to mostly quantitative, as it was with the LD literature, I have included this. Little has been discussed or researched about occupational stress in art therapists and I widened my search to include other arts therapists in consequence.

The final part of the Literature Review, Section 2.3, addresses resilience and how these qualities enable staff to manage stress. Self-care, particularly in terms of the use of creativity to manage stress, is then considered for LD staff, NHS staff, and for art(s) therapists.

As I searched for research from art therapists a gap in the literature was evident, as no British art therapists had researched occupational stress generally or related to any of the specialisms in which they work. This study addresses that gap. I investigated all the main arts therapies professions, which comprise art therapy, music therapy, dramatherapy and dance movement therapy. Disappointingly few art therapists had researched any form of occupational stress, and few other arts therapists had either; I included those that are relevant to my investigation.



Figure 7: 'Planes of Vision and Colour', October 2014

2.1 The Context of the Research

This section of the Literature Review addresses the context of the research, and answers questions about learning disability as well as discussing the situation facing people with LD in Britain and LD services in the last forty years. Secondly the context of work in the NHS is addressed, the pressures it faces as costs and demands made of it rise, then change in the NHS, and the impact of restructuring in terms of work intensification and job insecurity. Thirdly, art therapy is explained, and issues facing art therapists in their practice with people with LD are addressed.

2.1.1 The LD Context

What is a Learning Disability?

The term ‘learning disability’ is a label currently in use in Britain in NHS organisations such as the one I work in to describe people with reduced cognitive capacity, hence I am using this descriptor. Other labels that have been used previously include mental handicap, mental retardation, imbecile and feeble-mindedness (Sinason, 1992); intellectual disability and developmental disability are also labels currently in use. People with LD dislike being labelled, and should be valued and treated with respect as all humans should (BILD, 2017; Rees, 1998a; Sinason, 1992).

A person with a learning disability is likely to have a significantly reduced ability to understand new and complex information, and to learn new skills. They may have a reduced capacity to live independently, and their impairment started during childhood thus having a lasting impact on their development. Communication, managing everyday tasks and understanding risks are difficulties they experience, although some, particularly with milder LD are able to hold down jobs and marry (Rees, 1998a).

Learning disabilities are classified in NHS psychology teams in terms of intelligence quota (IQ), where a mild LD is said to be an IQ of 70 to 50, moderate LD 50-35, severe LD 35-20, profound LD below 20; the average person’s IQ is 100 (Holland, 2011). However, the British Institute for Learning Disabilities (BILD) consider this classification useful only if other aptitude tests such as those for adaptive functioning are used in conjunction. The more severe the level of LD the harder thinking and communication is, and the more challenging behaviour and unconscious communication are present when speech is not (Ashby, 2011).

A person's learning disability may be caused by a syndrome such as Down's or Fragile X, or by drug or alcohol use by the mother in pregnancy. Deprivation of oxygen during birth can result in brain damage, and difficulties can arise from premature birth; as well as illnesses such as meningitis, brain injury and environmental factors such as deprivation, neglect and abuse. Some people experience multiple causes (BILD, 2017). Emotional causes of learning difficulty, such as abuse and trauma, can respond to psychological treatment and may improve their IQ (Sinason, 1992).

Issues experienced by people with learning disabilities

The birth of a baby with LD shatters the hopes of parents and a period of mourning follows where there should have been joy (de Groef, 1999; Sinason, 1992). Historically people with LD were the subject of superstition, prejudice, persecution and rejection; disability was equated with evil and witchcraft. During the Middle Ages disabled people were targets for ridicule and jokes at their expense, and infanticide of disabled children was common place until the Victorian era. A state-run system of asylums was set up in 1845 and people with all kinds of disabilities were incarcerated, including those who were deaf, blind, or had epilepsy. They were often treated cruelly in the institutions, but life in the community was as bad. The lifetime segregation of disabled people was campaigned for in the early 20th Century amid eugenic fears that continued for two decades, but the inception of the welfare state began to change attitudes (Barnes, 1991).

Attitudes towards people with LD changed with the concept of Normalization, later known as Social Role Valorisation (Wolfensberger, 1983), which promoted social inclusion for people with LD, creating opportunities for taking on valued social roles in society, and changing views of people with LD as 'different'. Wolfensberger's ideas were developed to include respect, independent living, and choice, aiming to both protect and empower individuals who had been devalued by society. Another change of attitudes towards people with LD was brought about by Goffman (1961) who challenged how people were viewed, and revealed the impact of institutionalisation on patients and staff. Abuses of patients in institutions were uncovered in years that followed, and public outrage resulted in the Deinstitutionalisation Policy (Hamlin and Oakes, 2008).

This led to significant changes taking place in LD services over the last forty years as the result of Deinstitutionalisation which fundamentally changed the way people who have LD were cared for, impacting both clients and staff (Mansell, 2006; Skirrow and Hatton,

2007; Thompson and Rose, 2011). Change was needed in LD services because the workforce was ineffective and did not assist the personal development of clients (Baumeister and Zaharia, 1987).

Deinstitutionalisation involved the movement of people with LD, and other people with mental illness, away from incarceration in institutions separate from society to being cared for in the community (Hamlin and Oakes, 2008). Global recognition of the need for deinstitutionalisation brought about similar changes in other parts of the world, such as Sweden and the USA, during the same period (Ericsson and Mansell, 1996). In 1960 65,000 people with LD lived in institutions in Britain, but by 2003 the number had fallen to 1,500 (Emerson, 2004) and the process was completed by 2008. In 2009 the government started to encourage a model of supported living in their own home, where people held a tenancy and had much more choice over their everyday lives (Department of Health, 2009; Salmon et al, 2013).

People with LD were relocated to the community and experienced better residential care and physical surroundings, however there were still restrictions to their access to healthcare and other services (Bradley, 1996). Disparities in healthcare remained common (Alborz et al, 2005; Krahn et al, 2006; Morgan et al, 2000; Quality Watch, 2014), particularly in mainstream physical health services. Healthcare is still largely provided in specialist services, such as the multi-disciplinary community teams that took part in the study by Clare et al (2017), and that I and some of the participants work in. Transitions from child services to adult services were another difficulty for people with LD (Macintyre, 2014).

LD syndromes are associated with associated health difficulties, such as heart conditions and the prevalence of dementia for people with Down's Syndrome. Many people with LD are also on the autistic spectrum, and many experience epilepsy (Alborz et al, 2005). People with LD were found to have poorer health compared to the general population due to impoverished diets, obesity and physical inactivity (Robertson et al, 2000), and poor health is known to be related to poverty, bad housing conditions, unemployment and discrimination (Emerson et al, 2010). Social inclusion policies failed many people with LD as policies stated that people with LD should be accepted into mainstream health services and employment and social opportunities, but professionals working in those services were shown to lack the skills needed to work appropriately with people with LD

(Alborz et al, 2005). Even LD staff were not always able to communicate effectively with their clients (Bartlett and Bunning, 1997).

The way staff interacted with people with LD needed to change and person-centred models of care (PCP) were promoted by the government's Valuing People Policy (Department of Health, 2001), which benefited people with LD but were complex to organise (Cambridge and Carnaby, 2005). Lack of training, time, resources and staffing issues prevented the adoption of PCP in many places (Robertson et al, 2007) limiting choices available to residents.

People who have LD may experience further related difficulties such as a secondary handicap, an example of which would be infantilisation, in which the person is dressed and treated by their carers as if they are a young child rather than the adult they have become (Goody, 2012). When working with people with LD it is noticeable how often they smile, even when it seems inappropriate, Sinason (1992) refers to this as the 'handicapped smile'. This strategy is used by people with LD to please their carers, keep their approval, and to hide the primary handicap of the learning disability (O'Farrell, 2012). The strategy is indicative of learned helplessness, which is common in people with LD, as they often feel helpless and are unable to change their situations themselves (Wortman and Brehm, 1975).

People with learning disabilities are likely to experience abuse and neglect in the community, and to be highly vulnerable in society (Peckham, 2007) due to their social skills deficits which place them at risk (Kavale and Forness, 1996; Morrison and Cosden, 1997). Having a learning disability makes it difficult for people to prosecute their abusers and go to court, as they are often considered incapable of being credible witnesses, and capacity to consent is a crucial determinant (Green, 2001; Joyce, 2003; Sanders et al, 1997). They often experience hardship and social deprivation, especially if not living in supported accommodation, and struggle to make appropriate and safe friendships; they are likely to experience bullying and harassment, to be unemployed and to struggle with money management, reading and writing (Emerson and Hatton, 2008).

Three healthcare abuse cases were investigated, in Cornwall (Healthcare Commission, 2006), Sutton and Merton (Healthcare Commission, 2007), and forcibly came to the fore with the television revelation of the appalling conditions endured by people with LD in

the private sector at Winterbourne View Hospital (Flynn and Citarella, 2013; Plomin, 2013). The learning disability charity Mencap raised their concerns about disparities in healthcare in their 'Death by Indifference' report (Mencap, 2007). Hate crime experienced in the community is not uncommon (Bull, 2012).

Anger and aggression in people with LD can result in offending behaviour (Taylor, 2002), Attention Deficit Hyperactivity Disorder (ADHD) is prevalent, as are autism, mental illness, substance abuse, and challenging behaviour, co-existing with experiences of severe abuse, deprivation and hardship (Halstead, 1996). However, a fairly low proportion of people with learning disabilities become involved in the criminal justice system (studies using IQ to estimate prevalence reach lower statistics than those using wider criteria such as attendance at special school), and a large number of offences go unreported (Simpson and Hogg, 2001). Offending is more prevalent in people with mild and borderline learning disabilities, and most commonly include arson and sexual offences (Halstead, 1996).

As part of the Deinstitutionalisation process the 1996 Community Care Act addressed financial arrangements and introduced direct payments, which changed the way social care was provided. By 2003 personal budgets were introduced with the aim of empowering disabled people and giving them choice in their care within the community (Glasby and Littlechild, 2009).

Although Deinstitutionalisation changed a great deal for people with LD the advent of the global recession resulted in limitations to education and activities that could be accessed by adults with LD, and social care budgets were slashed. Many day centres and services that offered suitable work opportunities were closed, which left many people with LD with limited opportunities for suitable activities, and in addition many experienced poverty and associated disadvantages (Park et al, 2002).

Issues for staff working with people with LD

For staff, working in LD institutions was found to be moderately stressful, and organisational factors were often the most important stressor. Lack of control and workload, lack of job variety, being moved between units, role conflict, and disagreement with the therapeutic orientation of the unit were found to be stressors (Rose, 1995). Blumenthal et al (1998) found that staff in charity run homes had better wellbeing scores

than staff in NHS run homes; NHS staff reported not being listened to by the organisation, which had unreasonable expectations of its staff, as well as not giving residents as much choice over the way they lived their lives.

In community settings, wider organisational issues were less often a source of stress (Rose, 1995), whereas working conditions in day centres were characterised by excessive workloads, under-staffing, lack of resources, lack of flexibility of duties, being unable to spend time away from service users, and high noise levels (Mascha, 2007). Staff reported benefiting from supervision despite it being somewhat infrequent; team meetings also provided some degree of support.

High levels of staff turnover were an ongoing issue in LD services and a major concern (Rose, 1995), generally associated with staff stress (Hatton and Emerson, 1993), although other causes were found such as age, sex, low rates of pay and educational level. Turnover was a problem for clients whose attachments were frequently disrupted by staff leaving, and may have functioned to reduce numbers of poorly performing staff (Cope et al, 1987), though some staff left for positive reasons such as further education (Lakin et al, 1982) and promotion (de Kock et al, 1987). UK studies reported a wide range of turnover rates, from 5-48% (Felce et al, 1993).

Changing care provision from institutional to community living was not easy for staff who had to make the change, as their own, as much as the clients', institutionalised behaviour had to change (Salmon et al, 2013). This qualitative IPA study highlighted the difficulties the staff experienced, the training and support they needed to understand why change was needed and to calm anxiety, and the helpful role of supervision. Environmental issues also impacted the way services were provided, although community living allowed a more flexible approach to the care of LD clients and the chance for more personal contact.

Staff who moved from an institution to smaller residential homes were found to experience anxiety due to change, some resistance, and difficulty reducing institutionalised behaviours by Salmon et al (2013). There were both positives and negatives for staff and the clients involved, support from supervisors and team members was helpful. So was the different environment which allowed more personal choice for residents (so they did not have to take turns lined up for the bath, for instance, as bathrooms were en suite). Role ambiguity, changing rule-bound behaviour and flexible

working were all challenges, although training to understand the institutionalised behaviour that needed to change was helpful.

Client characteristics such as the slow rate, or lack, of progress in LD clients were found to be stressful (Sarata, 1974) and the prevalence of behaviour problems (Allen et al, 1991). Some staff found the sheer daily grind of caring with someone with challenging behaviour hard, and had difficulty understanding the behaviour, as well as coping with unpredictability and the apparent absence of a way forward (Bromley and Emerson, 1995). Observation studies found little change in challenging behaviour in clients following moves from hospital to community, but the subjective view of the staff was that it had increased. This suggested that staff felt less supported in the community, as there were fewer staff to assist during an incident, or that it was harder to manage the behaviour in the community (Emerson and Hatton, 1995).

Clients gained more recognition in community settings whereas they were low on priorities in institutions (Rose, 1995), and severely learning disabled people who moved from institutions to community settings had more support, contact from staff, and doubled their engagement in meaningful activity (Mansell, 1995). Day centre staff found they had similar issues, although some staff reported benefiting from contact with service users (Mascha, 2007; Søndena et al, 2015).

Changes within LD organisations because of Deinstitutionalisation significantly impacted staff and changed their roles in response to changes in service provision (Mansell, 2006). They were expected to adopt different values as they changed their way of working to a more person-centred model, resulting in some reports of role conflict (Allen et al, 1991; Rose, 1993; Thompson and Rose, 2011). However, role clarity was not a problem for the staff investigated by Blumenthal et al (1998) or the majority of staff in day centres (Mascha, 2007).

The impact on LD staff that worked one-to-one in the community with people who have challenging behaviour using the technique of Gentle Teaching (McGee et al, 1987) was investigated in a doctoral study (Start, 2008). The heuristic methodology of this study enabled the feelings and attitudes of the staff members to be clearly presented, showing how staff gradually felt more confident about their own abilities to manage challenging behaviour in clients as they got to know them. Fear and anxiety were prevalent and

experienced somatically by participants, but the method was transformational both for the client and the caregiver, so difficult feelings reduced over time and were replaced with more confidence and affection for the client.

The approach was other-centred, and required the caregiver to empathically respond to the client, and as caregivers gained experience in this manner of relating to people who had learning disabilities, the challenging behaviour reduced and both client and staff enjoyed each other's company most of the time. There always had to be some caution displayed however, because over-confidence could cause staff to be less aware of signs of distress, which could result in unexpected difficult behaviour (Start, 2008). Although this was a student dissertation, it was interesting to read about this approach to work with challenging LD clients, as it was the approach that was promoted in the specialist unit I worked in with this client population (see Chapter Three), and it was a heuristic study.

2.1.2 The NHS Context

The NHS under Pressure

The NHS is one of the largest employers in the world, with over 1.3 million staff (Sull et al, 2015). Its expenditure rose from £75.822 billion in 2005/6 to £117.229 billion in 2015/16, and it deals with over a million patients every thirty-six hours (NHS Confederation, 2016). The NHS is funded through taxation and the healthcare system is of national and political importance (Oliver, 2005).

The recession that began in 2008 has had a considerable impact on the NHS. Widespread austerity measures were applied to public services, and the health service continued to cost more because of increased chronic disease rates and people living longer (Anders and Cassidy, 2014). The population of the UK also grew in recent years due to migration and greater birth rates than deaths, thus the demand for, and consequent pressure on, the NHS's services increased due to such factors (Appleby et al, 2004).

Politically the NHS has always been under the pressure of financial constraints and programmes of change from governments (Oliver, 2005). The latest of these was the most complex, opposed and hotly debated in the history of the NHS, and introduced radical redesign in 2012, the year this study was undertaken. During this General Practitioner (GP) Commissioning Consortia had power devolved to them, although this was thought

to be beyond the capabilities of the organisation, at a time when it faced unprecedented spiralling costs (Klein, 2013).

Business approaches were applied to the NHS emphasising competition, choice and diversity of provider (Klein, 2013). This had begun when the internal market which separated purchaser and provider roles was introduced (Lapido and Wilkinson, 2002), and was opposed by the British Medical Association (BMA, 2010). It was designed to improve the efficiency of NHS organisations but also changed their values, as the BMA had feared, as saving money became their focus. Ironically, the statutory duty of the NHS Trusts is to break even financially, not healthcare (Lapido and Wilkinson, 2002). The Francis Report (2013) highlighted how a business focus compared to a client focus can result in warning signs of poor care being ignored.

In 2002 Payment by Results was introduced to the NHS, the private sector was recruited to extend the NHS's capacity, the power to commission services was devolved to local level and Foundation Trust status was introduced (Oliver, 2005). Hence there were, and continue to be, fears that the NHS would be privatised as health services expanded into the private sector, and massive programmes of organisational change were undertaken because of unrelenting pressure to reduce costs without cutting services. Opposition to the redesign of 2012 feared that the scope, scale and demanding timetable of proposed changes in the NHS would push the organisation to breaking point when the financial crisis was already putting a great deal of pressure on its services (Klein, 2013).

Quality Watch (2014) reported that many aspects of NHS healthcare had improved since 2012, however there were signs of strain in the NHS as patients had to wait longer for treatment, particularly in mental health services, and there were inequalities of care for marginalised groups. Inpatient beds were reduced by 17% and mortality rates were three times higher in mental health patients than the general population. Demand outstripped resources in mental health services where there were fewer doctors and nurses compared to physical health services, longer waits for Improving Access to Psychological Therapies (IAPT) services, an increase in the numbers of patients detained under the Mental Health Act, and more anti-depressants being prescribed (Quality Watch, 2014). It was noted that as state-funded social care in communities was decreased by 26% in the previous four years, waiting times had increased in the NHS. NHS failure became headline news when Mid Staffordshire NHS Foundation Trust was shown to have been guilty of significant

failures of care and radical change was found to be necessary to prevent further abuses taking place (Francis, 2013).

Another pressure on the NHS was rationalisation of the NHS estate. In 2005, the government advised NHS Trusts to form Estate Plans integral to their strategy to meet the needs of the local population they served. These should ensure they had appropriate, safe and secure buildings, that met environmental goals, minimised risk, incorporated infection control, and aided staff retention, morale and patient outcomes. The plans would also provide opportunities for Trusts to dispose of surplus or badly used assets and optimise occupancy costs (NHS Estates, 2005). A review of six NHS mergers showed that a considerable number of relocations of services between NHS sites and buildings had taken place (Aldwych Partners, 2011) and another area was reducing its portfolio of sites from 420 to 290 within six years (Dent, 2004).

Cheaper labour was valued over experience because it cost less, resulting in much anxiety for staff due to job insecurity, and many jobs being down-banded in a de-layering process (Hudson, 2002b). This resulted in a loss of experienced non-medical clinicians and the NHS relying on staff with less experience to do complex work (Keogh, 2014). A significant issue that has arisen because of downbanding processes during NHS restructuring is that of nurse retention, as nurses are leaving the profession, and even the country, due to disillusionment (Keogh, 2014). Nurse management positions are at the greatest risk of instability in the NHS but the numbers of nurses registered has been reducing, and there has been a reduction in overseas personnel recruited (Scott, 2002).

Work in the NHS intensified as a result of pressure on services, restructuring and reduced workforce as NHS Trusts sought to reduce their costs and increase the flexibility of their workforces (Hudson, 2002a). The 'acceleration debate' relates to the increased pace of life in industrialised countries including the UK, and particularly affects professionals and their work-life balance (Schöneck, 2015; Wajcman, 2008). This can be seen to be at work in the NHS, and 'time is money', characterised by less time for more tasks and a need to continuously adapt to increasing organisational changes is evident (Korunka et al, 2013).

Change for NHS Trusts

Change is an aspect of NHS employment that all NHS staff are extremely familiar with. The NHS has been undergoing a cycle of almost continuous reform and re-organisation during the last thirty years due to changes in government policy with the benefits being only moderately realised (Ferlie, 1997; Harrison and Wood, 1999; Jeffcoate, 2005; Klein, 2013; Litwinenko and Cooper, 1997; Oliver, 2005; Walshe, 2003; Webster, 1998). Adverse effects of NHS reform include enormous cost, a circular process too brief to have real beneficial impact before the next wave of reform begins, and deeply cynical attitudes among NHS employees who have seen it all before (MacIntosh et al, 2007; Marshall and Olphert, 2008; Walshe, 2003). In addition, there were considerable costs in terms of employee insecurity and psychological distress, although for some there were also opportunities (Appelbaum et al, 2000; Loretto et al, 2010).

NHS Trust mergers became commonplace but involved cycles of restructuring that sometimes appeared to revisit previous structures in different guises, and left staff with change fatigue and a lack of enthusiasm for the latest round of restructuring. Meanwhile normal operating procedures had to be managed, and concurrently wide-ranging changes were implemented (Klein, 2013; MacIntosh et al, 2007).

Studies into the impact of NHS mergers and restructuring processes were conducted by Goddard and Palmer (2010), Loretto et al (2010), MacIntosh et al (2007) and Marshall and Olphert (2008). Between three and six NHS Trusts were merged in each study, resulting in substantial change, and the impact found to be considerable on staff wellbeing and on Trust processes that needed to be integrated. The studies used mixed methods, collecting data from surveys and Trust documentation, and conducting interviews and group discussions with many staff over two to three years, apart from the smaller Marshall and Olphert study (2008) in which the qualitative interviewing took place in matched focus groups during one year. The study by Loretto et al (2010) included personal data in their analysis.

Integrating merged Trusts was found to be difficult, and some Trusts had failed to manage this process adequately. The MacIntosh et al (2007) study showed how two previous configurations of the five NHS Trusts involved in that merger had been considered failures, resulting in a further re-merger, and an attempt by the new organisation to evaluate the process to prevent another failure.

Merged Trusts still operated separately years after one merger, with their own policies and procedures still evident; policies were outdated and not applied across locality boundaries (Goddard and Palmer, 2010). The study by MacIntosh (2007) showed that the organisation aimed to improve this aspect of their merger, in which Trusts returned to a former configuration with the addition of an acquired failing Trust; the merger they studied included integrating all the NHS organisations in one rapid process. The studies found the staff in their samples were weary of ongoing change, disillusioned and that levels of work-related stress, affecting physical sickness levels and psychological wellbeing among staff, rose during restructuring processes.

Staff in different localities did not acclimatise to changes resulting from mergers because of lack of time, insufficient information and management support, causing feelings of disempowerment and withdrawal of trust and support for the new Trusts (Goddard and Palmer, 2010). Staff felt that even bad news was better than uncertainty which bred anxiety; change was unsettling, caused considerable disturbances to employees' work patterns, and were multiplied by being introduced into areas that were still feeling the impact of previous change (Marshall and Olphert, 2008).

Whereas the Goddard and Palmer (2010) study found work-related stress level of 38% in their sample, up from 33% the previous year, the sample in Loretto et al's (2010) study was lower at around 25%, and Marshall and Olphert's (2008) sample showed signs of 'presenteeism' (staff not taking time off sick or working long hours, perhaps due to fear of redundancy).

Job anxiety amongst NHS staff was not unfounded. There were job losses: in the MacIntosh et al (2007) study one hundred managers lost their jobs, whereas staff on lower bands were the most disadvantaged in Goddard and Palmer's (2010) study. Some staff in Loretto et al's (2010) sample lost their jobs, and others were moved to alternative roles; prospects of change of employer and terms and conditions of employment were also causes of stress. Changes in job security had a direct impact on mental health, and were not limited to actual and threatened job cuts but also to ongoing discussions over privatisation of the NHS, as well as uncertainty.

Change did not necessarily mean negative outcomes for all staff, as some change involved positive outcomes such as promotion and opportunities for development, and

autonomy was also a protective factor for their sample (Loretto et al, 2010). This study found that those who reported that their work had intensified in the previous year were at risk of ill-health. In contrast, increased training, promotion and improved job security proved to be beneficial to employee mental health. Having two children was protective, but one recent life event negatively affected staff mental health, and more than one increased the risk significantly (Loretto et al, 2010).

These studies showed that some NHS Trusts grew substantially through acquisition of neighbouring Trusts, and many were taken over, and these processes took place in the decade prior to the widespread restructuring experienced by participants in my study. This lends weight to the assertion that NHS Trusts undergo ongoing, and not necessarily entirely beneficial, processes of change, which impact staff wellbeing. Lack of communication and management support were consistently found to be problems, and staff anxiety rose particularly if their jobs were under threat. However, the studies also showed that some opportunities arose for staff, and training was beneficial.

2.1.3 Art Therapy in Context

Art therapy is a form of psychotherapy that uses art media as its primary mode of expression and communication. Within this context, art is not used as a diagnostic tool but as a medium to address emotional issues which may be confusing and distressing (BAAT, 2017)

Art therapy is a niche profession developing alongside more powerful, established and better represented professions, particularly those of medicine, nursing and psychology. The development of the profession in Britain between 1940 and 1982 was documented by Waller (1991), distinguished art therapist, one of the original art therapy pioneers and the first professor of art therapy in Britain. Waller's qualitative hermeneutic doctoral study (Waller, 1990), later published, described in detail the struggles that pioneer art therapists faced in developing posts and a professional representative body, gaining recognition by government with career and pay structures in 1982, as well as training and standards of practice.

State registration for art therapy became law in Britain in 1997 (BAAT, 1997) and art therapy progressed significantly as a profession in the years that have followed, and now has an established professional organisation with paid staff and a proactive approach to establishing the profession within the healthcare world. Art therapists work in many diverse areas which include education, prisons, hospices, mental health units, with a range of client populations such as people with eating disorders, LD, alcohol and drug misuse, dementia, trauma and abuse, oncology, children and adolescents (Waller and Gilroy, 1992).

The training for art therapists is a Master's degree, and there are currently nine universities in Britain offering training courses (BAAT, 2017). Maintaining their personal art practice was found to be hard after training and consequently the training courses changed their approach after educator Gilroy's (1992) research to encourage this aspect of their practice. It also became compulsory for art therapists to access personal therapy during their training, as it is for psychotherapists. Despite the increase in institutions providing training in art therapy there has not been a corresponding rise in the number of art therapy posts available on qualification, and training is expensive for those (the majority) who receive no funding, whereas in other professions, such as psychology, trainees are paid as NHS employees.

Most art therapists are trained with a psychodynamic understanding of their work, derived from psychoanalysis, particularly object relations theory, and work with unconscious processes of transference and counter-transference, and the healing qualities of image-making. The work of Jung and Winnicott has been of particular interest to art therapists, who work in a person-centred way, altering their approach with every person they encounter. Art therapists work with individuals and groups as appropriate (Waller and Gilroy, 1992).

Issues Encountered by Art Therapists

Management in the NHS was originally within occupational therapy (OT) teams, but moved over to psychology and arts therapies teams, as the understanding of art therapy (also known as art psychotherapy) as a psychological treatment was better understood (Edwards, 2004). Some areas of Britain are served by multi-disciplinary arts therapies teams employing music, drama and dance movement therapists in addition to art therapists.

The 2004 NHS pay review for non-medical staff had an impact on the profession. In my Trust this was a development that improved my status and pay, however, it was not advantageous across the board for art therapists as Usiskin (2007) discovered in her qualitative post-graduate research. She found that there was a 'raging anger' about situations some art therapists, including her, faced. They felt there was an enormous discrepancy between pay spines and a constant battle to justify their practice (Usiskin, 2007, p.56).

Deinstitutionalisation also had an impact on art therapists because of the changing environments in which LD and mental health patients lived and were treated. The move from institutional to community care hastened the loss of the studio approach that many found valuable and which underpinned the development of British art therapy practice (Case and Dalley, 2006; Deco, 1998; Gilroy, 1996; Huet, 1997; Killick, 1997, 2000; Woddis, 1992; Wood, 1992, 2000). Pressure on clinical space available for art therapy practice continued, and intensified with the reduction of NHS buildings during estate rationalisations. Many art therapists wrote about the importance of the therapeutic environment to their practice and to their clients, mostly in books and journals (Ashby, 2004, 2011; Case and Dalley, 2006; Deco, 1998; Falk, 2002; Gilroy, 1996; Huet, 1997; Killick, 1997, 2000; Moon, 2002; Morrison and Anderton, 2007; Sheppard et al, 1998; Woddis, 1992; Wood, 1992, 2000).

Ashby (2004, 2011) investigated the experiences of art therapists who work with people who have severe learning disabilities and challenging behaviour; she found that 25% of participants had difficulties with their physical working environment, either because it was situated in an inappropriate environment, or the room itself was not suitable. Foulds' (1998) case study raised relevant issues. She tried to provide a facilitating environment for her client but the centre where she was employed repeatedly failed to address her concerns, thus her client's experiences of disempowerment were echoed in her own. The considerable negative impact of Community Care on the availability of rooms for art therapists was also discussed by Hall (2001) in her dissertation study.

Ford (2007) described difficulties with the art therapy space she was using in an NHS hospital due to health concerns over the management of silica dust from pottery work in the studio, which the Trust refused to address. The situation resulted in unpleasant treatment by management, causing sickness and she left her post. A position paper

written by art therapists facing difficulties with their working environments (Morrison and Anderton, 2007) asserted that fierce competition for space was experienced by NHS-employed art therapists who found themselves working in far smaller spaces, sharing multi-functional rooms or losing studio space altogether. They considered that management failed to understand their view that the therapeutic space was integral to therapy, and consequently art therapists were being expected to provide a service in ‘totally inappropriate and inadequate conditions’ (Morrison and Anderton, 2007, p.22).

Organisational issues were raised by educator Edwards, who wrote about the impact of the organisation as well as profession specific issues, such as art therapy being viewed as peripheral by the medical profession and being poorly understood (Edwards, 1986, 1989). He used psychoanalyst Menzies Lyth’s ground-breaking research into nurses’ experiences in hospitals (Menzies Lyth, 1988) to inform his own understanding of his situation and warned art therapists of the need to be aware of institutional dynamics where they work as they cannot contend with the institution unless they understand the social defence system they are part of. Edwards encouraged art therapists to draw on Menzies Lyth’s ideas to help them understand the unconscious processes that may be at work in their institutions. Several art therapists have gained training in organisational consultancy and acknowledge the need to intervene at an organisational level to reduce workplace stress (Huet, 2011; Westwood, 2007).

The difficulties of working as an art therapist in a therapeutic community whose orientation is work-based were discussed by Mahony (1992) who found that art therapy was not readily accepted by the organisation. Within the mental health institution where Rogers was employed there was a lack of understanding about art therapy, resulting in Rogers feeling ‘alternately greatly appreciated and powerful, or marginalised, impotent and guilty about not being good enough’, with a sense that art therapy was being undermined (Rogers, 2002, p.65). Rogers sensed that art therapy was considered dangerous in her institution, amid a mistrust of art and artists, and fear of ‘emotional leakage’ which inclined institutions and their staff to ambivalent reactions to art therapists (Rogers, 2002).

Art therapists who worked with people with severe learning disabilities and challenging behaviour described the difficulties they encountered in the work (Ashby, 2004, 2014b; Foulds, 1998; Rees, 1995; Stack, 1996; Tipple, 1992). Rees described her first experience

on a ward as distressing and one of ‘deprivation, distress, chaos and mayhem’ (Rees, 1995, p.120) and Tipple discussed difficulties establishing stable and positive relationships with members of this client group (Tipple, 1992). A survey investigating the work of art therapists with this client group found that art therapists experienced extremes of emotion ranging from joy and elation to despair and disempowerment, and needed sufficiently supportive infrastructures to continue their difficult work (Ashby, 2004, 2011). Ashby discussed the fear that is experienced by art therapists working with clients with challenging behaviour (Ashby, 2012).

Countertransference issues commonly experienced by art therapists who worked with people who have learning disabilities were discussed by Rees (1998), writing of her innovative doctoral research. Disempowerment left therapists feeling totally deskilled and wondering whether the work was pointless, and the therapist could be invaded by the same feelings of inadequacy and self-doubt the client felt. Anger was felt in response to the client’s helplessness and a desire to champion their cause, or a dead feeling of all consuming boredom could sweep over the therapist like a thick blanket which robbed the therapist of her vitality and life force, preventing engagement between therapist and client. Rees equated this feeling with one of suffocation or drowning and wrote of the powerful nihilistic feelings therapists experienced with this client group. Good-quality supervision was essential to enable therapists to work through these experiences and create a ‘metaphorical survival space’ (p.241).

Stack’s (1996) interesting post-graduate case study examined two years of individual sessions with a man with a severe learning disability who exhibited autistic, obsessional, idiosyncratic and challenging behaviours. She interviewed staff members who had worked with her client, and others who had not, using video, to analyse the work and its impact on her client. She wrote of the difficulty of struggling to understand for long periods of time, inertia, feelings of dizziness, headache and inability to think, and getting stuck because of resistance and frustration. Communication problems contributed to her difficulties and she spent much time trying to decipher her client’s verbal and pictorial communications. Stack also indicated the importance of good supervision, gaining understanding through theories that help make sense of the work, and the benefits of further training.

art therapists whose practice was being changed by licensing boards that did not value art therapy (1997). She also conducted heuristic research into the impact of working in toxic environments for art therapists whose art practice and creativity was consequently negatively impacted, including her own (Kapitan, 2003).

The necessity of developing an evidence base for art therapy practice if the profession was to remain competitive within the NHS was of concern for the profession (Gantt, 1994), and found to be very beneficial for those who engaged in it, as many art therapists did in the context of postgraduate Continuing Professional Development (CPD). HCPC require and audit, and BAAT encourage, the recording of CPD. Several art therapists wrote about research that art therapists might find conducive to their experience of practice, such as Gilroy (2006), Kapitan (2010), Karkou and Sanderson (2006) who wrote about research for the arts therapies and McNiff (1998) who focused on an art-based approach. Edwards (2016) reported on the wide range of research methods being evidenced in the arts therapies, largely focused on marginalised people groups.

Difficulties gaining art therapy employment were discussed by Kyriakidou and Gale (2012) who, talking from experience, stated that, while the employment scenario has not changed in terms of the lack of opportunities available for art therapists, it had in terms of the processes prospective employees had to engage in. Human contact was reduced through electronic processes, and after applying for posts candidates may hear nothing more; searches for art therapy work will yield no results and should be widened to include mental health related work. The British Association of Art Therapists focused many of its efforts on exploring potential employment opportunities for art therapists, and creating resources that supported those efforts their members made (Richardson, 2013).

2.2 Occupational Stress and Burnout

In this section I investigate occupational stress in general terms, then address burnout; next I look in depth at the impact on LD staff, NHS staff and art(s) therapists.

2.2.1 An Overview of the Occupational Stress Literature

What is Occupational Stress?

External pressures and triggers can produce physiological and emotional responses in our bodies which become stress reactions. Occupational and personal stress occur because of exposure to pressures and triggers in the workplace and at home. Reactions to stress take place within the brain and body as the autonomic nervous system responds (ANS); the ANS is responsible for control of bodily functions outside our normal consciousness, such as breathing, the heart beating, intestinal activity and so on. Within the ANS are the sympathetic and parasympathetic nervous systems, which govern these reflexes (Kahn and Saulo, 1994).

Stress was first understood by Selye (1956, 1978) as having both good and bad qualities, which he called eustress and distress, building on the work of Cannon on homeostasis (Cannon, 1932). Bodily arousal in response to stress gave rise to the theory of ‘fight or flight’, in which the sympathetic nervous system is stimulated and the body prepares for combat by increasing adrenaline, heart rate and blood pressure, sugar production for energy, and sweating, while the parasympathetic system shuts down peripheral vision, hearing, digestive and other bodily functions (Kahn and Saulo, 1994).

More recent bio-behavioural research questioned theories of human reactions to threats to their survival involving only primary responses of ‘fight and flight’, most previous studies having investigated male responses. A study into women’s responses to stress found that an increase in the hormone oxytocin encourages women to nurture their offspring to protect them from harm, and to affiliate with social groups to reduce risk, called by researchers the ‘tend-and-befriend’ response (Taylor et al, 2000). It may be that women tend to react to stress by seeking and giving social support (tending and befriending) rather than by withdrawing behaviours, and perhaps this finding may also extend to members of the caring professions of either sex.

Extended exposure to stress in the workplace and the body's reactions can lead to the development of physiological disease symptoms, as well as to psychological distress and psychiatric disorders. Minor physiological symptoms of stress are experienced daily by individuals at work who feel stressed (Mazzola et al, 2001; Scott et al, 2010). During daily routines people experience as many as twenty to fifty small emotional responses to events which trigger a state of activation and stress, and the cumulative impact of these constantly triggered responses can be the development of headaches, digestive disorders, sleep disturbance, fatigue, and backache (Sedlacek, 1989).

More seriously, physical illness may develop in varying degrees of severity, from mild somatic symptoms to chronic terminal illness. Stress is linked with cardiovascular disease, hypertension, cancer, asthma, rheumatoid arthritis and neuroses (Taylor and Cooper, 1989), thyroid disease (Wentz and Nowosadzka, 2013), intestinal permeability and other autoimmune diseases (Axe, 2016; O'Bryan, 2016). Therefore, the repercussions of occupational stress can be serious for those who are affected, and there can be few people who are not to some extent.

Occupational stress leads to psychological distress and psychiatric disorders in some people (Taylor and Cooper, 1989). In contrast, job satisfaction is positively correlated with both physical and mental health (Faragher et al, 2005). Occupational stress can lead to Burnout, as can other syndromes such as Compassion Fatigue (Figley, 1995) and Vicarious Traumatization (Pearlman and Saakvitne, 1995).

Occupational Stress Research

Many occupational stress models, of which burnout is one, have been developed to enable researchers to understand the cause of occupational stress on workers. Many of the models can be combined, so some of these models, or combinations of them, are used in burnout studies.

Interactional stress models focused on the impact of different aspects of the work environment on individuals and their perceptions of these issues, and a model that was influential for many years was the Person-Environment Fit model (P-E fit) developed by Caplan (1983). This considered that strain was experienced by individuals who experienced a lack of fit between their needs and capacities, and the demands and provision of their employment. Lack of fit was thought to take three forms: 1) demands

of the work situation exceeded the worker's capacity; 2) the worker's needs were consistently not met by the environment; or 3) a combination of these situations existed so that the individual's needs were not met and their abilities were overstretched. Lack of fit could result in health problems of both a physical and psychological nature such as anxiety, panic attacks, disturbed sleep, raised blood pressure, lowered immunity, and raised serum cholesterol (Edwards et al, 1998).

A similar model developed by Karasek (1979) was the Job Demands-Control model (JD-C). This focused on job demands, considering tasks required by the work in which issues such as time pressure and role conflict could arise, and the amount of control the worker had in terms of authority to make decisions, and the breadth of skills required to do the job. Johnson and Hall (1988) added social support to these factors, giving rise to the Demands-Control-Support or Iso-Strain model, in which the importance of social support to moderate stress was recognised; a high-risk situation was one in which there were high demands, low control and low social support.

The Effort-Reward Imbalance model (ERI) developed by Siegrist (1996) was based on ideas of distributive justice, where if the effort exerted by the worker was met with insufficient reward the resulting imbalance produced stress, and resultant behaviours and risk to health. Interactional theories built upon each other, and combinations of these models were found by researchers to be more useful than the different models in isolation (Cox and Griffiths, 2010; Ganster and Perrewe, 2011), as were combinations of quantitative and qualitative data (Schonfeld and Farrell, 2010).

Transactional theories were concerned with processes like cognitive appraisal and coping styles and emanated from social and clinical psychology. An influential transactional model of psychosocial stress was developed by Lazarus (1966; Lazarus and Folkman, 1984) and proposed a subjective interaction between person and environment, in which stressors that impacted one person may not stress another in the same way. Stress was viewed as a cognitive response to an environmental demand, in which two processes of cognitive appraisal and coping mediated between external stressors and the person's responses. Primary appraisal entailed assessment of the nature of the perceived threat, whereas secondary appraisal resulted in either problem-focused coping (practical responses to stressors in situations that could be changed) or emotion-focused coping

which involved an effort to find a strategy to alleviate the negative impact of a situation that could not be changed.

Organisational developments of Lazarus' model added appraisal of the worker's ability to meet the demands made of them and recognising that this could change due to tiredness, illness or age. Under- and over-demand were added to the dimensions, so that monotonous or too challenging work practices were recognised as stressful, as was the impact of the worker's internal needs, and health and safety frameworks (Cox and Griffiths, 2010). Individual stress appraisal and coping dimensions were developed by Dewe (Dewe and Cooper, 2007).

The concept of the Psychological Contract between employee and employer (Morrison and Robinson, 1997) was an implicit agreement that governed employer and employee relationships and behaviour. The model concerns mutuality and the employee's beliefs about the reciprocal exchange arrangement between them and their employer, an unwritten expectation of job demands and rewards particularly related to job security. This model was applied to research into employment conditions for health professionals, for instance by Shield (2002), in relation to a merger between NHS Trusts.

Psychodynamic therapists considered that the existential importance of work in the development of a sense of significance and self-worth was at the root of the problems of many individuals who developed burnout when their careers no longer fulfil their existential needs (Maccoby, 1980). Once an understanding of the relevance of these factors and their relationship to unconscious career choices, the professional interests and activities of the individual's parents, and the dynamics of their relationships with them has been gained, burnout could be overcome, they found (Pines and Yanai, 2001).

Most of the research conducted into occupational stress and burnout has been based on one, or a combination, of the interactional and transactional theory models, and far fewer have been conducted qualitatively. I have only given a brief overview of some different theories of interest to this study.

Burnout

Since being observed by psychoanalyst Freudenberg (1974, 1980), burnout was found to be a significant problem across the world and has been extensively researched amongst

workers in many different occupational contexts. These include mental health social workers (Evans et al, 2006), staff in LD services (Hastings, Horne and Mitchell, 2004), music therapists in multi-disciplinary teams (Hills et al, 2000), teachers (Hakanen, Bakker and Schaufeli, 2006), substance misuse professionals (Oyefeso et al, 2008), career counsellors (Pines, 2003), mental health staff (Pines and Maslach, 1978), child and youth care workers (Savicki, 2002), colorectal surgeons and nurses (Sharma et al, 2007), military personnel and police officers (Burke and Deszca, 1986), librarians (Birch, 1986) and even truck drivers (Kemp, Kopp and Kemp, 2013), to name a few.

Maslach (1982) described burnout as having three dimensions: emotional exhaustion, depersonalisation and reduced personal accomplishment. Emotional exhaustion results from workers becoming emotionally drained while working with people, and over time becoming exhausted. Depersonalisation describes the avoidance of contact with and decrease in concern for clients that occurs when people feel exhausted by their work, and these two factors result in, or are experienced in addition to, reduced efficacy and perception of accomplishment in the worker. Occupational stress could result in burnout, as a result of a cumulative impact, characterised by a pervasive psychological decline involving changes in attitude and behaviour (Schaufeli and Buunk, 1996), as a result of the depletion of an individual's energy resources (Shirom, 1989).

Human service professionals were considered particularly susceptible to burnout because of their inherent need to derive a sense of existential significance from their work (Pines and Aronson, 1988). Pines and Maslach (1978) noted that higher rank and length of service, too many hours at work, and too much engagement with administration tended to result in less concern for and contact with clients. Interpersonal demands of helping relationships were identified as sources of stress and subsequent emotional exhaustion, because although these could be rewarding they could also be emotionally charged and personally demanding (Devereux et al, 2009a).

An investigation into whether burnout dimensions were dynamic and subject to patterns of change during a worker's lifetime in a survey, repeated over two years, of over 2,000 health professionals, found it was only slightly at times of change, such as for newcomers and job changes, but was stable for longer-term workers (Dunford et al, 2012). Hence the Maslach Burnout Inventory (Maslach, 1982) is the most widely used instrument in burnout studies.

Cumulative organisational issues (Cherniss, 1980; Maslach and Leiter, 1997; Thompson and Rose, 2011) and job demands such as workload, conflict, lack of key resources such as control, social support, autonomy, involvement in decision-making and coping strategies were identified as antecedents for burnout (Maslach, 1999). LD studies found that job insecurity, challenging behaviour, role conflict and work-life imbalance were also antecedents for burnout (Blumenthal et al, 1998; Borritz et al, 2005; Bosman et al, 2005; Dekker and Schaufeli, 1995; Devereux et al, 2009b; Kozak et al, 2013; Rose et al, 2004; Skirrow and Hatton, 2007).

Many managers believe the issues pertain to individual workers and do not concern them, however the syndrome is widespread and an expensive problem for organisations (Maslach and Leiter, 1997). In Holland and Sweden burnout was designated a medical diagnosis (Schaufeli et al, 2009; Friberg, 2009), and in 2016 Sweden introduced shorter work days because research had shown that this increased productivity and led to a happier workforce (Alderman, 2016).

A positive psychology approach considered work engagement to be the antithesis of burnout, characterised by vigour (high levels of energy and mental resilience at work), dedication (having a sense of pride, significance, enthusiasm and inspiration at work) and absorption (being engrossed in one's work, concentrating fully) (Demerouti et al, 2010). Burnout and work engagement were considered to be opposite ends of a continuum, although others might suggest a burnout-job satisfaction continuum, as job satisfaction was found to combat burnout (Faragher et al, 2005; Kozak et al, 2013).

2.2.2 Occupational Stress and Burnout in LD Staff

The LD research was mostly quantitative and generally concerned with support staff, sometimes mixing staff groups in heterogeneous samples, but only occasionally addressing occupational groups as the general research literature had. Meta-analyses conducted by Rose (1995), Skirrow and Hatton (2007), Devereux et al (2009a), Disley et al (2009) and Thompson and Rose (2011) concluded that variations in methodology and inadequate reporting of methods made interpretations and conclusions tentative and unreliable. The usefulness of the LD occupational stress research was therefore limited, however the studies seemed to show that the move from institutional care to community life was beneficial for clients and their staff (Skirrow and Hatton, 2007; Thompson and Rose, 2011). More recent studies seemed better conducted.

Burnout was increasingly the subject of research with LD staff because it had implications for service delivery (Hastings et al, 2004), and organisational factors were found by Skirrow and Hatton (2007) to be the most predictive of burnout. The impact of psychological stress on staff behaviour was shown to result in negative interactions with service users (Innstrand et al 2002; Lawson and O'Brien, 1994) and thus was of concern to employers (Skirrow and Hatton, 2007) who also had a duty to ensure the well-being of their workers (Hastings 2002).

Several cross-sectional survey studies found that community staff perceptions of clients' challenging behaviour impacted their burnout scores. Chung and Harding's (2009) study showed that how staff viewed their client's challenging behaviour depended on their personal outlook, in terms of their agreeableness, neuroticism and extraversion; the more challenging behaviour was perceived as a threat the greater was the likelihood of burnout. Fear of assault lead to more emotional exhaustion, and if perceptions of LD workers could be changed through training, even though the challenging behaviour may not, this could result in lower stress levels, a study testing this approach found (Rose et al, 2013).

Søndenaa et al (2015) found that community nursing staff showed more signs of stress and burnout when exposed to challenging behaviour, but were more compassionate and focused on relationships than their counterparts in a forensic unit; there was a higher ratio of female staff in the community sample. The community staff scores suggested they found their work more demanding but also more satisfying, and they had slightly higher resilience scores too, however levels of challenging behaviour experienced were not measured. Similarly, a study comparing staff in a medium secure unit with community staff found that the staff in the medium secure unit reported less fear of violence and greater self-efficacy in the medium secure staff, although surprisingly burnout scores across both groups were comparable (Howard et al, 2009).

A demographically matched sample of 84 community and hospital LD staff found that the hospital staff experienced considerably higher levels of aggression and of emotional exhaustion, even though the community staff felt equally self-efficacious in managing the challenging behaviour they experienced daily (Hensel et al, 2013). This correlated with the fact that LD clients were more often admitted to hospital because of severe behaviours, but being a quantitative study could give no more insight into the difference.

These studies showed that exposure to challenging behaviour did raise levels of emotional exhaustion in LD staff, and increase the risk of burnout.

A cross-sectional survey of 400 LD staff in 30 residential settings, most of whom were female, had been employed there for an average of five years, and half of whom worked full-time, while the other half worked part-time (Kozak et al, 2013). 60% worked with people with high care needs, some worked on-call and night shifts, but 64% had experienced physical aggression and 81% verbal aggression. 40% of respondents, mostly female and aged 30-39 years, reported higher burnout scores, though few had the highest burnout scores. As the previous studies found, this study also found challenging behaviour was an antecedent for burnout, as were emotional demands, work-life and role conflict, job insecurity and lack of feedback, showing supervision was helpful. Researchers noted that personal factors were not investigated and may have had a bearing on the results; higher burnout scores correlated with intentions to leave (Kozak et al, 2013)

Role ambiguity was associated with an increase in conflict and work burden, and with an increase in staff burnout (Allen et al, 1991; Kozak et al, 2013; Rose, 1993; Thompson and Rose, 2011), though not by Blumenthal et al (1998) or Mascha (2007). Aitken and Schloss (1994) and Boumans and Van den Berg (2000) found there was greater role clarity with the introduction of the person-centred approach. Conflict between work and home life was found to be a problem by Hatton et al (1999) and Kozak et al (2013). Job insecurity was also found to be a significant stressor by Bosman et al (2005), Dekker and Schaufeli (1995) and Kozak et al (2013).

A systematic review of the LD literature found that organisational climates with better person-environment fit promoted greater job satisfaction and reduced burnout scores (Thompson and Rose, 2011); for instance, staff in suitable environments, and provided with appropriate training for dealing with challenging behaviour, had lower burnout scores. The result of deinstitutionalisation was shown to have been beneficial in reducing staff burnout over time (Skirrow and Hatton, 2007), although there was a rise in burnout levels of supervisory staff during the process (Edwards and Miltenberger, 1991). Burnout scores for the Blumenthal et al study (1998) varied between residential homes, suggesting local variations in the person-environmental fits achieved.

A survey study into the perceptions of members of five multi-disciplinary integrated community teams (MDTs) for people with LD in one English county was conducted by Clare et al (2017). The MDTs consisted of NHS art and music therapists, psychologists, nurses, occupational therapists, psychiatrists and speech and language therapists, and care managers including social workers, commissioning and monitoring provision, under the leadership of the local authority.

The study found an absence of vision within the organisation, which lacked a permanent head of department, and a dominant culture strongly focussed on bureaucracy and process, which hampered the ability of its members to respond proactively to the needs of their clients, although there was good interaction between team members. Wellbeing scores showed that 4% of staff were burnt out, and more than half had worrying scores on the MBI scales, consistent with other LD studies such as Hastings et al (2004), Skirrow and Hatton (2007). The health staff felt less supported by the local authority than their social care counterparts, and their training needs were not understood. For health staff who had worked in the team longer, there was a sense of isolation from their NHS Trust due to restructuring (Clare et al, 2017).

2.2.3 Occupational Stress and Burnout in NHS Staff

There are many studies on occupational stress and burnout in NHS staff from different professional groups, including Bowers et al (2006), Brown et al (2006), Burgess et al (2010), Currid (2008), Cushway and Tyler (1996), Edwards et al (2006), Evans et al (2006), Loretto et al (2005), Loretto et al (2010), Mann and Cowburn (2005), Nelson et al (2009), Oyefeso et al (2008), Ross et al (2009), Sharma et al (2007), Sherring and Knight (2009), Sheward et al (2005), Sweeney and Nichols (1996), Thompson et al (2008), Weinberg and Creed (2000). In addition to some reports analysing surveys of NHS staff, I used mostly qualitative studies and two quantitative studies that addressed the issues I wished to draw out; I excluded studies such as Mann and Cowburn (2005) because of their low sample.

Several reports analysing NHS staff surveys showed how stressed NHS staff felt, and how stretched NHS services were. Quality Watch (2014) reported that NHS staff stress rose between 2011 and 2013 (spanning the year in which I interviewed my participants), and 38% of staff who completed the NHS staff survey reported having been ill as a result of work-related stress. The report noted that these were the highest levels of stress

reported since the NHS staff survey began, and there appeared to be a related reduction in compassionate care as noted by the Francis Report (2013). A shift away from short-term financial efficiency planning was needed, to thinking long-term about relational value because NHS values had been undermined by the pressures staff experienced, another report on an NHS staff survey declared (Wilkinson, 2015). Doctors reported that the pressure the NHS was under was unprecedented, and organisations were attempting to do more with less; consequently, the staff were feeling the impact. There had been a 400% increase in demand for a confidential counselling programme for NHS doctors and dentists, GPs reported their workloads were unmanageable and unsustainable, and ambulance staff were reported to have the highest levels of stress of NHS staff (Wilkinson, 2015).

Eight psychologists in the NHS, who were interviewed as part of a wider study on relational narratives (Nutt and Keville, 2016), identified that organisational change within their Trust had negatively impacted their working conditions, and they worked in a 'tick box culture' where creativity was quashed. They experienced systemic pressures and lack of time due to work overload. Thinking was squeezed out so patient-related decisions were rushed, less time was spent liaising, consulting and informing colleagues, and the staff did not have a safe context to express stress, anxiety or mistakes. Clients and staff felt they were treated like numbers, there was a lack of consistency, and teams became dysfunctional as relationships were strained and time constraints prevented them being established. Consequently more patients presented in crisis, the standard of care reduced because of feelings of dehumanisation, demoralisation, disempowerment and reduced emotional energy. Compassion in the staff was inhibited because of feelings of being deskilled and lack of support, and there was a sense of threat from the organisation that resulted in a hypervigilant response (Nutt and Keville, 2016).

As noted earlier, the studies of NHS mergers found there were issues with staff mental and physical health (Goddard and Palmer, 2010; Loretto et al, 2010; Marshall and Olphert, 2008; MacIntosh et al, 2007). In more general terms, a case-control study of nurses, doctors, administrative and ancillary hospital staff investigated the impact of work issues, personal vulnerability (marked by the lack of a confidant and a personal or family history of psychiatric disorder) and domestic issues, in terms of psychiatric disorders (Weinberg and Creed, 2000). Disappointingly no members of professions allied to medicine were included in their sample, however this was only the second quantitative study I found that

included consideration of personal factors when investigating occupational stress in the NHS. Sixty-four pairs of cases and controls, matched demographically, were interviewed, and variables entered into a logistic-regression analysis; cases were likely to lack social support, have had a previous psychiatric episode, and greater personal and work issues, while controls did not. The study confirmed that, even when personal stress and vulnerability were taken into account, work stress could still lead to or perpetuate depressive and anxiety disorders in NHS staff. The issues were particularly evident for employees who were vulnerable to mental health issues, and those with severe domestic stresses, such as marital problems, personal illness and that of a close relative. Employees who lacked management support and those who experienced chronic role conflict issues were also affected (Weinberg and Creed, 2000). The study by Loretto et al (2005) had similar findings.

Eight mental health nurses were recruited to a hermeneutic phenomenological study that addressed the stress inherent in their work with challenging, unpredictable and acutely ill psychiatric patients in semi-structured interviews (Currid, 2008). Their environment was chaotic, under-resourced, and characterised with a heavy workload; they felt de-skilled which impacted their self-worth. They had dilemmas and pressure around bed availability and the early discharge of patients not ready because more acutely ill patients needed to be admitted. The nurses felt that levels of violence and aggression were not taken seriously by higher management, and they were waiting for a serious incident to happen before notice was taken; they experienced fear of assault. They felt clinical work was not valued as highly as financial, administrative or managerial tasks. They could not easily switch off when home, were worried about a blame culture, and did not receive enough support.

A study into the impact on eight community psychiatric nurses (CPNs) of working with people who engage in deliberate self-harm (DSH), using semi-structured interviews and IPA, found the nurses tried to understand the function of the DSH and develop a therapeutic relationship with the patient. They reacted differently depending on the DSH that patients presented, understanding them to have intrapersonal and interpersonal functions, and in response felt strong negative emotions, particularly anxiety and hopelessness. The CPNs felt burdened by their responsibility towards the patient, trying to give them responsibility but fearing a negative outcome. They felt insufficiently supported and needed more supervision and training (Thompson et al, 2008).

Nurses from twenty-seven Scottish (n=4,721) and thirty-one English NHS hospitals (n=5,006) were surveyed regarding the impact of staffing shortages on emotional exhaustion and job dissatisfaction levels (Sheward et al, 2005). The Maslach Burnout Inventory, the Nursing Work Index, and demographics including job characteristics, shifts, and decision making (in the UK only) were used, and logistic regression models in the analysis process. Two thirds of the sample worked full-time and the rest part-time, predominantly female, half had dependent children, and they were on grades D to F, half being on the middle band E. 40 % of Scottish nurses worked overtime (some paid, some not) and half the English nurses. Workloads were reported to have increased in the last year, and 27% of Scottish and 34% of English nurses were found to have high emotional exhaustion scores. 60% felt that nursing care was good or excellent, but a sizeable minority (10% across both countries) were dissatisfied with their post and their work as a nurse, and almost one-third were planning to leave their post within 12 months in both countries. As the number of patients the nurses felt they were responsible for increased (varying from up to 4, 5-8, 9-12, or 13+) so did their burnout scores.

Work-life balance was an issue for palliative care nurses who found that personal relationships were compromised by the demands of their work; they experienced sleep disturbance and irritability, and often were not able to ‘switch off’, as did the nurses in the Currid (2008) study. Some experienced stress to the point of taking sick leave, and talked of feeling burnt out and wanting to leave nursing. Others felt their capacity to cope was diminished by experiencing multiple deaths concurrently, and because of the emotional intensity of the work (McCloskey and Taggart, 2010).

2.2.4 Occupational Stress and Burnout in Art(s) Therapists

Much has been documented about occupational stress in psychotherapists but in comparison little in relation to art therapy and the other arts therapies.

Psychodramatist Kirk’s (1999) doctoral research investigated the impact of work with survivors of childhood sexual abuse (CSA) on therapists, and described her own experience of burnout while working as a therapist with this client group. She was an insider researcher, and disseminated a questionnaire to nineteen therapists addressing the issues utilising a Delphi cycle, and conducted five meetings of a co-operative inquiry group with six members including herself. Kirk found that the therapists had to engage in balancing acts to counter various aspects of the work that threatened to overwhelm

them due to powerful emotional disorientations that arose. All felt de-skilled by the work and further training helped but the feelings remained; regular, adequate supervision and support were prerequisites for protection against the impact of the work. The ultimate strategy identified was to quit.

The only British art therapist to address the issue of occupational stress and burnout was Edwards (1986, 1989), writing in the late 1980s in the British art therapy journal. Edwards worked in a large Victorian institution and initially struggled considerably to establish his practice (Edwards, 1986). Many art therapists worked in similar conditions and opportunities for employment were scarce, as they remain (Kyriakidou and Gale, 2012). They faced issues such as role conflict and ambiguity within departments with different frames of reference, understaffing and isolation, and Edwards felt the situation taking its toll on him. He described feeling ‘suspicious, angry and increasingly isolated’ and concerned primarily with his psychological survival (p.4). Awareness of such difficulties led Edwards to urge art therapists to develop coping strategies that were neither defensive nor destructive, describing the risks of burnout (Edwards, 1989).

Evidence of the impact of the work faced by art therapists in therapeutic relationships was found in case studies (Rothwell, 2008; Ashby, 2015), journal articles (Lavery, 1994; Edwards, 1997; Kinnetz, 1988; Hardy, 2001; Bardot, 2008), and theoretical texts (Tipple, 1992; Waller, 2001; Wheeler and Smith 2001; Hardy, 2005; Sibbett, 2005; Killick, 2007; Ashby, 2012). There was also evidence from published research (Ashby, 2011; Gilroy, 1992; Huet, 1997; Rees, 1995; Stack, 1996). Dynamics in the therapeutic work, particularly the transference (projection of unconscious attitudes, feelings and needs emanating from childhood onto the therapist) and countertransference (the therapist’s response), can result in a range of feelings in the art therapist which are often extremely uncomfortable, and yet are central to their understanding of the work.

Meunier (2015), a Canadian who conducted a heuristic self-search into her own need for self-care during her art therapy training, found the pressures affected her physical and psychological functioning. She experienced disrupted sleep, depleted physical and mental energy, and reduced contact with family and friends because of work pressures. She was aware of leg/foot and shoulder/neck pain due to sedentary aspects of the work, psychic isolation and emotional pain from her therapy clients’ emotional material and its confidential nature; she also experienced emotional depletion to the point of exhaustion.

She noted that the dual roles of student and therapist increased the pressures she experienced.

Burnout in arts therapists

Four studies conducted since 2000 were found, one by art therapists, and the other three by music therapists. Gam et al (2016) investigated burnout and coping strategies in 140 Korean art therapists, collecting demographic information, and using scales to measure self-efficacy (Lee, 2003), coping strategies (Kim, 1987), and an adaptation of the MBI by Choi (2002). High levels of self-efficacy were found, the art therapists most commonly sought social support when stressed, and had low levels of burnout. Those who had longer careers and established supervision were more self-efficacious, also used emotion-relieving coping strategies and had lower burnout scores; therapists who lacked supervision and had higher caseloads showed greater indications of burnout.

Clements-Cortés (2006) examined the occupational stress experienced by four music therapists working in in-patient palliative care using semi-structured interviews. Sources of stress identified related to contact with clients, and included their ongoing experiences of loss, and countertransference issues experienced in sessions with clients which included feelings of helplessness. Organisational issues they experienced included a lack of understanding of the music therapist's role and being expected to juggle multiple roles; they also suffered from a lack of suitable clinical space and funding issues. Their levels of stress were found to be within a normal range.

Surveys conducted by Fowler (2006) and Hills et al (2000) utilised the Maslach Burnout Inventory (MBI), another questionnaire and devised relevant demographic questions of their own. Fowler's study investigated levels of burnout in forty-nine music therapists, comparing their attitudes, longevity at work and their working conditions. Questions regarding control over the work environment, value of work by colleagues, comfort with and input into administrative policies were included. Music therapists who had left the profession because of burnout could not be contacted because they no longer appeared on professional registers, so instead of professional drop-out Fowler measured professional longevity and considered factors contributing to professional well-being. The data showed that positive mental attitudes and coping strategies were correlated with greater professional longevity and the converse was also true; it was also found that lifestyle changes at the onset of burnout could change the outcome.

The study by Hills et al (2000) aimed to assess experiences of role ambiguity and music therapists' identification with multi-disciplinary teams (MDTs) and their profession. The respondents' scores of burnout were found to be in the mid-range for scores of emotional exhaustion and personal accomplishment, and the lower third for scores of depersonalisation. Music therapists working in MDTs had a greater sense of personal accomplishment than those not working within teams and tended to identify more with their profession. Sources of reward were fulfilment from clinical work, team working, colleagues, feeling appreciated, and playing or using music therapeutically; sources of pressure reported were lack of understanding about music therapy, organisational issues, heavy workloads, clinical issues and colleagues (members of MDTs identified more problems with their organisation and colleagues than non-MDT members).

Job Satisfaction

Although an important aspect to consider when addressing the impact of the work is that of job satisfaction, little has been documented by arts therapists concerning the rewards of their practice. Edwards (1997) described the experience of leaving an art therapy post in which he had been employed for seven years, and although he encountered many difficulties working within a medical model in the employing institution, he considered the experience to have been of 'immeasurable value'. He described the experience as 'establishing ... congenial, and at best 'good', object relations within [his] inner world', a process that continued to 'nourish and sustain' him (Edwards, 1997, p.55). 62% of 311 art therapist respondents to a survey said they were happy with their career choice (DuBeau, 1993); this post-graduate survey was disappointing as it was extremely brief.

Data from four qualitative interviews conducted by Clements-Cortés (2006) reported positive benefits from practising as a music therapist in terms of job satisfaction, from experiencing intimacy in therapy sessions and knowing their work was valued by clients. Sources of reward identified by 151 music therapist questionnaire respondents (Hills et al, 2000) included fulfilment from clinical work, team working, and feeling appreciated, as well as contact with colleagues, and playing or using music therapeutically. Rykov (2001), writing of her experience as a music therapist, felt that, despite the difficulties encountered in work in palliative care, music therapists' lives were enriched by their work.

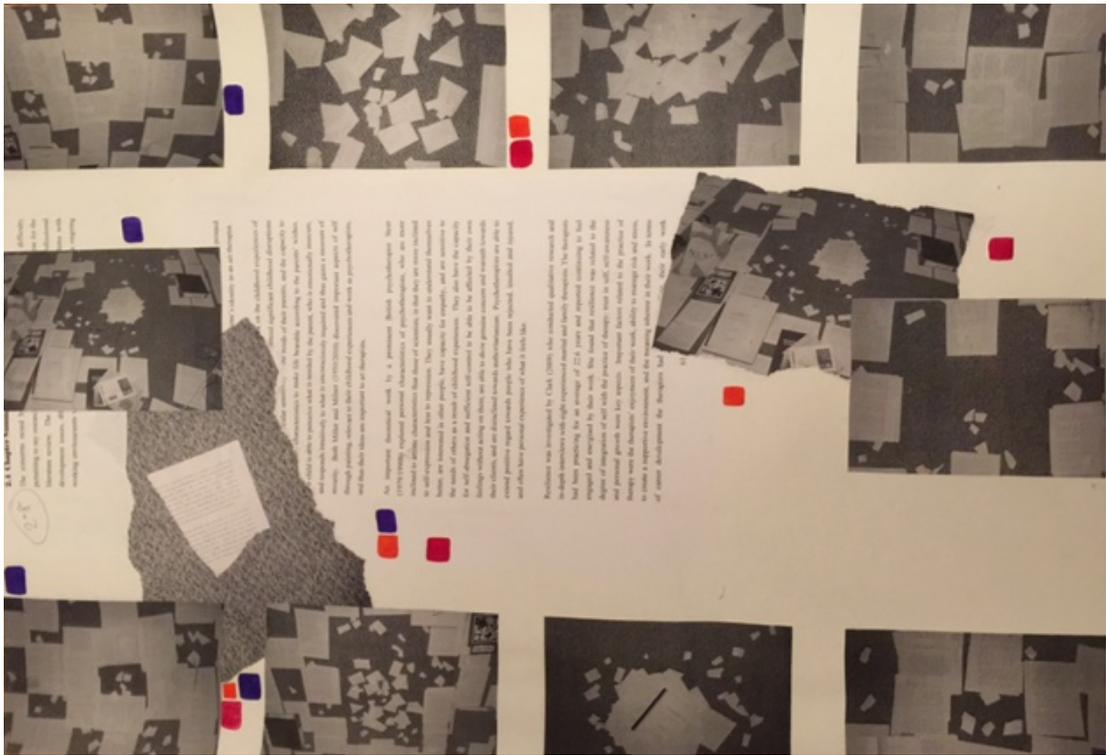


Figure 9: 'Patterns of Paper-Strewn Study', February 2012

Norcross and Guy (2007), in their comprehensive critical analysis of the psychotherapy research literature, stated that there were more benefits to psychotherapy practice than hazards. The greatest satisfaction was found to be helping people, promoting growth and alleviating distress; therapists valued the intellectual stimulation and acquisition of wisdom which resulted from their work, and the emotional growth gained from working with different personalities and challenges.

Psychotherapy is a career that provides a sense of purpose and meaning in life; therapists enjoy being in relationship with other people, listening, conversation, and opportunities for intimacy. Their capacity to relate to partners and friends, and to intervene in family situations, increases in proportion with their emotional growth. In addition, a successful practice provides great satisfaction for clinician and client, increases employment opportunities, professional reputation, and consequent financial rewards (Norcross and Guy, 2007). I included this study because, in the absence of much information from arts therapists, I thought it likely that art therapists have similar experiences.

A meta-analysis of 485 job satisfaction studies with a combined sample size of nearly 268,000 workers found that job satisfaction was protective against burnout, depression, anxiety, and physical ill-health, and was associated with higher self-esteem (Faragher et

al, 2005). Finding one's job interesting, with a good income, supportive work relationships, autonomy and career advancement opportunities were associated with job satisfaction (Sousa-Poza and Sousa-Poza, 2000).

2.3 Resilience and the Management of Stress

Resilience

Resilience is a factor likely to protect against occupational stress (Skovholt, 2001) and refers to the ability of individuals to cope with and rise above difficult and stressful situations, to successfully adapt and maintain competent functioning, and to bounce back afterwards (Sull et al, 2015). Three possible outcomes were noted by Lynch et al (2013): recovery, sustainability and growth. Recovery refers to the ability to regain equilibrium and positive functioning in the face of difficulty, trauma and other highly stressful situations; sustainability is about pursuing goals and desired achievements; and growth was defined as the development of greater self-knowledge and of new understanding gained. Resilient people were found to be optimistic with a sense of purpose in life (Smith and Zautra, 2008), able to maintain a sense of balance, and positive mental and physical wellbeing. Resilience can be developed over time given the right circumstances (Sergeant and Laws-Chapman, 2012), hence education in healthcare settings is important.

Art therapist Bardot (2008) discussed the development of resilience in herself and her clients in a theoretical paper. She recognised the need for self-awareness, and to address her own wounds and allow them to heal to be able to work within palliative care with her clients' wounds. She noted that many of the clients, with sufficient support, worked through their pain and recovered a sense of coherence in which they could determine meaningfulness in life again. She herself had been through this process, and had developed resilience that enabled her to work with trauma in the hospice.

Bardot acknowledged that her personal experience of art therapy, supervision, and continual creative exploration of her feelings through art, journaling and poetry, enabled her to work with trauma and loss, even though it reminded her of her own trauma and loss. She advised therapists to seek out support and supervision to address their own trauma and additional losses, to help maintain empathy and nurture therapeutic bonds, in agreement with Hardy (2001, 2005) and Waller (2001). Working in this way enabled her to witness resilience and growth in clients as well as herself (Bardot, 2008).

Resilience in therapists was investigated by Clark (2009) who conducted qualitative research and in-depth interviews with eight experienced family therapists. The therapists had been practicing for an average of twenty-two years and reported continuing to feel engaged and energised by their work. She found that resilience was related to the degree of integration of self with the practice of therapy; trust in self, self-awareness and personal growth were key aspects. The therapists' enjoyment of their work, ability to manage risk and stress, to create a supportive environment, and the meaning inherent in their work were important factors. The therapists had a sense of calling, their early work experiences were positive, and when they were stressed by their work environment they moved to more flexible situations. They moved jobs when appropriate, nurtured supportive relationships, and undertook further training. The participants had weathered difficult and stressful situations in the past, had been proactive about managing them, and engaged in effective ongoing self-care.

Self-awareness is very important for NHS staff due to the pressures they face, and it is crucial that health practitioners attend to their own wellbeing (Urdang, 2010). A study of resilience in 845 NHS staff of all professional groups and bandings in one Trust in Northern England found that most had moderate levels of resilience. Ancillary staff scored lower levels, with administrative and clinical staff with management responsibilities scoring slightly higher (Sull et al, 2015). Women scored higher than men, as did older people and those working part-time hours between 18.75 and 37.5 hours per week; on banding those on the lowest NHS band and medical staff scored lowest. These results suggested women tend to be more resilient than their male counterparts, and resilience increased with age and experience. Clinical staff scored lower than admin staff and managers, and the researchers associated this with agile working and having less contact with supportive colleagues. Older women who worked part-time were more resilient, probably due to the likelihood that they reduced their hours to increase their quality of life.

The definition of resilience supplied by Wicks (2008) pointed to surviving and thriving as central to the concept. Wicks advised therapists to enjoy good things now and not put off having fun or learning skills until later in life, and to nurture relationships which provide us with encouragement, challenge, perspective, laughter and inspiration. He considered balance to be important, avoiding conservativeness and procrastination, and processing unfinished business. He pointed out that attending to organisation and

productivity could reduce much stress. Being aware of indications of possible burnout, such as boundary violations, unhealthy self-medicating, withdrawal, verbally attacking people or overworking was necessary (Wicks, 2008).

Empowerment

Empowerment of patients and carers was high on the agenda in the NHS to ensure their voices were heard (DOH, 2000) but culture was slow to change after the introduction of Patient Advice and Liaison Services (PALS) in NHS Trusts in 2002. Not enough staff training or resources were available to empower PALS officers to act within their organisations, ironically (Anders and Cassidy, 2014). Burgess (2014) found that as healthcare managers felt more empowered their resistance to change reduced, however Akter (2012) found that doctors were empowered and consulted before changes that impacted their working practice were implemented, but nurses were not. Both groups were said to be highly motivated at work, despite the nurses being significantly disadvantaged but it reduced their job satisfaction.

Nursing assistants who felt empowered performed better, stayed in post longer and felt happier in their work; their self-esteem increased, they experienced greater satisfaction, showed more commitment, and were less stressed (Cready et al, 2008). Structural empowerment involving access to information, support, necessary resources and opportunities for personal development influences nurse retention, burnout, and job satisfaction. Authentic leadership experienced as relational transparency, ethical conduct, balanced processing and self-awareness further empowered recently graduated nurses, and significantly reduced burnout in experienced nurses (Spence Laschinger et al, 2013).

Creativity and Healing

There is a considerable body of research into the healing nature of creativity and the arts, and their use in self-care strategies. In attempting a definition of creativity Runco and Jaeger (2012) stated that it requires originality and effectiveness. Cognitive ability, talent and personality must be matched by the labour of love that creative people engage in; arousal is necessary for creativity but too much stress is detrimental (Torrance, 1988). Creative people were described as intelligent, adventurous, radical, emotionally sensitive, with good ego strength; introspection and independence, along with non-compliant attitudes were part of their creative nature (Lauronen et al, 2004). Increased enthusiasm, self-confidence, mood, energy and speed of mental association were experienced.

Cropley (1990) found that characteristics of creative people included openness, autonomy, playfulness, humour, flexibility, willingness to take risks and perseverance, which contributed to mental wellbeing.

Educational psychologists conducted a content analysis of 90 papers on creativity, and their conclusions resulted in a definition of creativity as an interaction between ‘aptitude, process, and environment by which an individual or group produces a perceptible product that is both novel and useful as defined within a social context’ (Plucker et al, 2004, p.90). Creativity is important for problem-solving and other aspects of thinking, contributes to health and emotional wellbeing, and is important for academic work and for success in adults. Creativity has been found to be important in many widely different spheres, from children’s education (Torrance, 1962; Renzulli, 1994) to business (Amabile, 1998; Stevens and Burley, 1999).

Psychologists and psychotherapists consider therapy to be a creative endeavour between therapist and client (Harter, 2007; Leitner and Faidley, 1999; Raskin, 1999), an essential element of the therapeutic dialogue if life-changing processes were to take place. For therapists to be able to engage with clients in this way within therapy they must themselves be engaged in and familiar with creative processes (Harter, 2007). The methods needed for each therapeutic endeavour have to be spontaneous, as each therapeutic process is unique; processes include investigation, self-development and reinvention, narrative construction and conversational elaboration (Raskin, 1999).

Harter, a personal construct therapist, wrote about the therapist as person-as-artist, as she expanded Kelly’s person-as-scientist metaphor, and his ideas about the creativity cycle (Kelly, 1955/1991), drawing on art therapy literature. Harter’s theoretical paper postulated that therapists were engaged in creative processes with their clients where there was an ongoing ‘interplay between professional and personal construing’ (Harter, 2007, p.172). Prescriptive approaches to therapy limited therapists’ creativity and denied the connected nature of trauma and healing that was part of the therapeutic process for both therapist and client. As our efforts to understand our experience are often not verbalised or conscious the therapist’s approach needed to go beyond the purely verbal. Visual art provides a means for expression that is unique in its ability to span time, space, juxtaposition of elements, and to elucidate meaning, encourage experimentation, and change one’s view of a situation.

Other art forms, those of music, reading and writing, poetry, singing, dancing and acting were found to be personally enriching and to contribute to psychology practice by a group of personal construct psychologists (Scheer and Sewell, 2006). Sullivan argued that imaginative and intellectual work made by artists was a form of research, and that misconceptions about visual arts meant that its contribution was undervalued (2005).

Research processes were considered creative by dance movement therapist Meekums (1996) because of an interaction between originality and experience in a 'potential space' (Winnicott, 1971) as the researcher moves between states of stillness, of active receptivity, and striving and action. Interestingly, she described a repeated spiralic movement during the research process of preparation (which she preferred to call striving), incubating, illuminating and verification (Boden, 1990), similar to illuminative evaluation methodology developed by Parlett (1974, 1981). This research process seems comparable to the heuristic approach of Moustakas (1990) that I have been working through.

People suffering chronic pain, who used art to help them manage their emotions and give meaning to their lives and pain experience, had to modify and adapt creative processes to enable them to use them, and learn new techniques (Lynch et al, 2013). The participants' resilience was linked with their creativity, and assisted them to overcome their circumstances and depth of suffering in a way that fostered personal growth, fulfilment and transformation, connection with others, a sense of control and of existential meaning.

Brown, a dance-movement therapist, investigated the relationship between arts therapists and their art, inside and outside work, and asked what happened if they stopped making it (Brown, 2008). She conducted three art-based poststructuralist research inquiries with forty-five art and dance-movement therapists, forming thirteen sub-groups using image-making and creative forms of improvisation to answer the research questions. Brown discovered that maintaining their art processes resulted in transformation, wholeness, completion, spiritual depth, containment, contemplation, connection and cleansing for the arts therapists. When they failed to sustain their art practice, they experienced depletion, anger, apathy, and disconnection from themselves, their work and patients. She also discovered that all the participants continued to maintain their art practice while working, found the creative process important for their effectiveness as therapists, and for their personal wellbeing.

A study of undergraduate students about to take major examinations found that a brief period of art making (30 minutes) significantly reduced anxiety, as compared to students in a control group with no access to art (Sandmire et al, 2012).

Creativity is at the heart of art therapists' outlook and approach to life and work (Gilroy, 2004). Resilience is acknowledged to be characteristic of artists and creative people in general, characterised by recovery, sustainability and growth, and in some people optimism (Lynch et al, 2013; Gregerson, 2007). The capacity to use creative resources to assist recovery from illness is also widely recognised amongst art therapists (Reynolds, 2004; Sibbett, 2005; Van Lith, 2015), hence it is part of the rationale for their employment within the NHS.

Wellbeing and Balance

A balanced cross-sectional survey of 156 British therapists investigated positive and negative aspects of therapist well-being (Linley and Joseph, 2007) and found that humanistic and transpersonal approaches to therapy were predictive of growth, but cognitive behavioural approaches were predictive of burnout. The therapeutic bond was most likely to produce positive psychological changes and job satisfaction and reduced likelihood of burnout; likewise having a sense of coherence related to less negative psychological change, compassion fatigue or burnout. Female therapists, having had personal therapy, clinical supervision, and a trauma history were all aspects associated with positive psychological changes and less burnout, but therapists who had been working longer experienced more negative psychological changes and burnout. A greater number of therapy hours and higher caseload was associated with more satisfaction and growth. Wellbeing was highly associated with job satisfaction in a meta-analysis of almost 500 occupational stress studies (Faragher et al, 2005).

An IPA study into work-life balance in twenty-nine occupational therapists (OTs) was conducted by Clouston (2014) who found that work in their healthcare and social services settings had intensified, required multi-tasking, and reduced time and energy for home life and appropriate self-care strategies. There was pressure to achieve outcomes in less time than was possible, reduced autonomy, and increased hours of work. Pressures from work ate into family time, caused family stress and reduced leisure activities. Weekends became more packed, energy was depleted, and routines became tedious with little light relief possible. The organisations' emphasis on neoliberal capitalist values caused

imbalance in the OTs working lives because it increasingly demanded more and participants did not experience job satisfaction.

Participants in a mixed methods study found that there were limits to the availability of flexible work arrangements for nurses, depending on their roles in the organisation, and the needs of the service which had to be balanced against the needs of the individual and the team (Harris et al, 2010). Managers who had more autonomy could work more flexible hours than ward staff on long days, and policies that intended to make flexible working easy to arrange were not practical in some settings. Older nurses did not perceive the policies applying to them and did not ask, and managers thought that the policies were idealistic but difficult to manage in practice. Managers became gate-keepers but only a few people could work flexibly in teams so competing demands had to be prioritised while trying to keep their team happy, and some older nurses without childcare responsibilities may have been disadvantaged.

Different aspects of flexible working arrangements could reduce or increase work-life conflict and pressure on the individual (Russell et al, 2007). The female ratio in the workforce had increased over the past decade and was expected to continue to rise, and the workforce was also increasingly ageing. Four types of flexible working were investigated: flexi-time, working from home, part-time work and job share arrangements, though others were available such as career breaks and term-time only work. Working part-time and flexi-time were more common, and more likely to be used by women. This reduced work pressure, but working from home could increase the pressure felt by the household. The culture of the organisation could also have a bearing on whether work pressures decreased for those working flexibly.

2.3.2 Self-Care Strategies

Image-Making as a Form of Self-Care

Art therapists are convinced of the value of the therapist's own artwork in sustaining them in their practice and through difficult life events but do not always manage to follow their own advice. Lavery (1994) and Wadson (2003) advocated using image-making to process the impact of sessions with clients, and Iype (2010) used art to articulate and process her grief after a major bereavement; she also felt the experience transformed her

work with patients. Halliday (1988) and Sibbett (2005) found image-making and use of their art therapy skills invaluable in their fights against cancer.

Rogers' image-making and experience as an artist assisted her to face dark aspects of her work with older and dementing patients. She wrote of her need to create images because of the sense of immense loss experienced by all around her and symbolically evoked in the environment in which she worked. She argued that images created by art therapists are a 'massively undervalued resource, which has distinctive potential for mediating the emotional impact of their therapeutic practice' (Rogers, 2002, p.71). Similarly, Bardot, an art therapist working in palliative care, concurred with Hardy (2001) on the need to attend to their reactions to constant loss. She developed resilience and experienced healing through her own experience of art therapy and supervision, and ongoing processing of her feelings through art, journaling and poetry (Bardot, 2008).

Although Gilroy (2004) described her art practice as something of a struggle to maintain she stated that it underpinned and informed everything she did and was a crucial aspect of her life. She advocated image-making for personal fulfilment and maintenance of health, and maintained that art practice fulfils an existential need, enjoyment, a source of refreshment, self-affirmation, self-discovery and insight, and as such was invaluable.

Tipka demonstrated that art-making used for self-care alleviated symptoms of trauma and described how she and her co-researchers used image-making to experience relief, express intense emotions, and to explore disruptions in their sense of self. Images also helped to soothe them, take their minds off their work and to restore their sense of balance and well-being (Tipka, 1999). Art therapists Cohen et al (1995) produced a book utilising image-making and reflective writing for the relief of trauma symptoms, useful for both clients and therapists.

Artwork is connected to our soul, to our inner selves, and immersion in one's art process is 'risky, dangerous and invigorating. To walk that path is to be alive' (Allen, 1992, p.28). Allen was concerned about 'clinification' of art therapy, where the art therapist becomes less and less involved in the art-making processes in therapy and their own lives; she saw this as contributing to art therapists experiencing burnout, career drift, and lack of research and of theoretical depth within the profession. She believed, as did many others,

that the effectiveness of art therapists depended on their personal art practice (McNiff, 1989).

Psychologist and artist, Harter (2007) progressed through an experience of loss through her own image-making and music, finding that drawing and painting changed her view of herself, suggested new possibilities, and greatly enhanced her work as a therapist. In visual art she encountered the sacred, its capacity to transcend violence in the world or in relationships, and its capacity to go beyond the obvious.

A qualitative study into the role of art in the lives of ten seasoned psychotherapists who were also visual artists found that they used art as powerful forms of self-care, as a passionate engagement (Tansino, 2007). The participants described the drive to make art, and the impact of their artist self on their whole lives – they did not consciously use art to process their countertransference or to cope with stress but found it helped. They experienced absorption, transcendence, existential meaning, spiritual connection (to people, nature, the world), timelessness, and being in the liminal space when they were creating art. They needed to make time to engage with their art form (painting, sculpting, photography, mixed media and jewellery-making), and felt nurtured and energised by their art – it was a ‘source of joy, relaxation, exhilaration, challenge and pride’, and made them feel alive (p.72). Creating art resulted in a tangible and concrete product that gave immediate feedback, positively counteracting the abstract and intangible nature of clinical work, and gave a sense of accomplishment and control over the process (Tansino, 2007).

Transformative art practices were developed by art therapist Kapitan (2003), who worked with ‘disenchanted’ art therapists who reported working in toxic environments, as part of a heuristic doctoral study designed to restore creative vitality. This intervention study used art, story, myth and dream imagery in sessions with the art therapists to reconnect them with their creative souls and process their deleterious experiences, and thus restore them to a happier and invigorated sense of self.

Supervision

I was surprised to discover how little supervision to address the impact of the therapeutic work on the art therapist was discussed in terms of self-care in art therapy literature. Many art therapists discussed painful and distressing countertransference feelings, and expressed how important supervision was to help them think about and process the impact

of the work. However, when Rees (1998) reviewed the literature on the purpose of supervision no mention was made by authors she reviewed of art therapists' need for supervision as a form of self-care, and she only touched on the subject by implication. The same was true of a more recent book on art psychotherapy supervision, which made little overt reference to the subject of art therapist self-care (Schaverien and Case, 2007). Edwards (1986, 1989) and Kirk (1999) emphasised the importance of supervision to enable therapists to survive the impact of the work, as do most art therapists.

The need to maintain a boundary between supervision and therapy may be one reason for the omission, but Schaverien (2007) points out that therapists need to feel able to discuss current aspects of their personal life that may be impacted by their work. She discussed a situation where unconscious processes, emanating from client material, interfered with a therapist's life and supervision enabled the 'spell' to be broken, freeing the therapist to make practical adjustments to her life that were needed. The psychological health of the art therapist was discussed by Wood (2007) in relation to supervision and she pointed out that the art therapists' regulatory body Health and Care Professions Council (HCPC) requires therapists to monitor their own health.

Though art therapists tend to write little about their own experience of the distress they encounter in their therapeutic work, art therapists who have written about transference and countertransference issues in the context of work with particular client groups have highlighted the importance of supervision to help them process this material and as a form of self-care (Edwards, 1986, 1989, 1997; Hardy, 2001; Rees, 1998b; Rogers, 2002; Rothwell, 2008). The importance of the therapist's image-making in supervision has also been discussed (Brown et al, 2003; Henzell, 1997; Rees, 1998b).

Further Strategies Identified

Research may be a framework that enables the art therapist to manage countertransference issues, according to Rees, who discussed the part her research played in enabling her to cope with powerful feelings of disempowerment and to continue to work in what she describes as 'grim conditions' with people who have severe learning disabilities (Rees, 1995, p.135). Many art therapists working with this client group seek additional training and engage in research within Master's degree programmes, due to feelings of being de-skilled and disempowered that they experience in the work (Ashby, 2004, 2011). Writing up a case study of her work with a client whose material was difficult to think about was

found to be very helpful to Stack (1996, 1998) within the context of a Master's degree, and Iype and Voorhees described journeys of self discovery through the difficulties of their research projects (Iype, 2010; Voorhees, 1994). Research as a method of self-development and personal growth was experienced by some therapist researchers as more powerful than their experience of personal therapy, particularly autoethnography and heuristics, and other reflexive research methods that use the researcher's story as a basis for the research (Etherington, 2004b).

The increase of web-based applications, while increasing administrative tasks for NHS staff, can benefit them too. Distance learning can facilitate CPD for community practitioners, promoting flexibility, enabling development of specialist skills, and making it easier for employees to fit their learning into their busy work lives, so facilitating better work-life balance and empowering the learner (Southernwood, 2008).

Art therapist Kinnetz (1988) reported the need for self-awareness and regular self-monitoring of her needs to preserve energy and prevent burnout, a point that is as relevant today as it was then. Advice to music therapists working with the dying offered by Rykov included the need for conscious self-awareness, acceptance of imperfection, meeting and working through emotional pain, and developing 'a flexible tolerance for ambiguity and ambivalence' (Rykov, 2001, p.190).

Clements-Cortés (2006) reported that her music therapist respondents cited self-care strategies that included exercise, following a healthy diet, and reducing stress at home; taking short breaks and planning vacation time, and using music recreationally were helpful, as well as spending time with family and friends, meditation and prayer. It was suggested that it was beneficial for music therapists to work part-time in the palliative care setting, have regular breaks during work hours, and to have government-provided funding. The participants reported job satisfaction resulting from experiencing intimacy in therapy sessions and knowing their work was valued by clients. However, about half of professional employees and managers do not take a lunch break, working through, although it has been shown that taking a break increases productivity (Burke, 2009). Similar strategies were identified by Fowler's music therapist respondents, in addition to attending conferences, prayer, leaving work at the office and focusing on good things (Fowler, 2006).

In view of the evidence of high levels of stress among NHS staff, and the difference that having a supportive manager makes, supportive stress management would seem to be a high priority for the NHS. However, the NHS Knowledge and Skills Framework (KSF) was found to be lacking key components of necessary management skills by a well-designed study into the competencies needed by managers for the effective management of workplace stress (Lewis et al, 2010). Their findings were corroborated by Goddard and Palmer (2010). Nineteen competencies were identified through semi-structured interviews with forty NHS employees and managers, compared with only eight in the KSF. Effective management of workload and resources, individual consideration of employee's situations, and the importance of a participative approach in which people's views were sought were among the competencies not addressed. Given that it is well-known that nurses experience a high level of stress, a skills framework for managing stress was necessary for the NHS (Lewis et al, 2010).

Weinberg and Creed (2000) recommended an approach to stress management that included the availability of psychological interventions, and an organisational component that addressed issues in the working environment, such as difficulties with unsupportive management. This approach was endorsed by Mackareth et al (2005), and would seem to go beyond the normal levels of self-care needed, into stress management and recovery. Workplace wellness initiatives were discussed by Blake and Lloyd (2008) who found that NHS staff were negligent about their own health and wellbeing, despite regularly giving such advice to patients. It was evident that the NHS needed to change organisational 'health culture' in order to encourage employees to take their own health-care more seriously.

Adequate social support was identified as an important stress management policy for staff working with LD clients in the community (Skirrow and Hatton, 2007). Social support was found to act as a buffer against stressors (Ganster et al, 1986), to have direct impact on stress levels, and to meet human needs for belonging, regard and understanding. Personal characteristics and social contact between staff and clients become more important in smaller community facilities where more time was spent in interaction, and challenging behaviour was more tolerable if mediated by social support (Rose, 1995). LD staff working in community settings had less contact with teams and colleagues, and often there were communication problems. However, the availability of resources such

as money and transport enabled staff and clients to access more interesting activities, and involved contact with other staff within the organisation.

The use of mindfulness in reducing occupational stress in LD clinicians and other NHS staff has been demonstrated, and is popular in the research literature; this approach was being introduced into LD services for stress management purposes (Alexander et al, 2014; Brady et al, 2012; Byron et al, 2015; Cohen-Katz et al, 2005; Goyal, 2014; Krasner et al, 2009; Noone & Hastings, 2010; Pipe et al, 2009; Shapiro et al, 2005; Singh et al, 2004).

Norcross and Guy's (2007) research and experience-based guide to self-care considered that a dual focus was necessary to enhance functioning at work and at home, and for therapists to thrive not just survive. They advised employing multiple self-care strategies within diverse theoretical traditions, prioritising self-care within their week and scheduling self-care activities in their calendar to ensure they were not squeezed out.

They recommended strategies that valued the person of the therapist, such as encouragement through appreciation of the rewards of practice, recognising and pro-actively managing the potential hazards, and nurturing important professional and personal relationships. The importance of attending to bodily needs and thought processes, as well as the importance of working within a flourishing environment and sustaining healthy escapes from working life were promoted. The necessity of maintaining appropriate boundaries was advised, undergoing personal therapy when needed, cultivating spiritual aspects of life and attending to existential needs. In addition, fostering creativity and growth, attending to continuing professional development and creative approaches to life were beneficial (Norcross and Guy, 2007). Resources like this self-care guide would be beneficial for art therapists, though there are others (Baker, 2002; Kottler, 2010; Pope and Vasquez, 2005; Weiss, 2004; Wicks, 2008).

Sinason (1997) pointed out that therapists working with difficult client groups needed to be adequately supported by supervision, workshops, further training and possibly their own therapy. Garfunkel's method (1995) for avoiding burnout despite working with suicidal patients entailed carefully keeping boundaries between her home and work-life and careful documentation of her work.

Rothschild (2006) advocated the importance of body awareness for prevention and treatment of compassion fatigue and burnout. She discussed mind-body interaction through the autonomic nervous system (ANS), considering what happens to the body during psychotherapy sessions when therapists are experiencing countertransference, projective identification, synchronicity, emotional contagion and empathy. Synchronicity between therapists and their clients was such that each was influenced by the other, unconsciously, through their autonomic nervous systems.

Negative coping strategies included drinking too much coffee and alcohol, risk-taking behaviours like speeding, and withdrawing from friends and family were identified (Steed and Downing, 1998). Coping strategies that aim to reduce client contact employed by therapists working within difficult organisational contexts were identified by Parry and Gowler (1983). These strategies are symptomatic of the burnout dimension of depersonalisation (Maslach, 1982) but many workers are subject to overload, and some organisations may even be guilty of using burnout to reduce staff levels (Pines, 1982).



Figure 10: 'Acquisition of Knowledge', March 2012

2.4 Chapter Summary

The Literature Review has shown how frequent and wide-ranging change is in the NHS, without necessarily achieving substantial benefits. The changes alter working conditions, induce occupational stress through job insecurity and greater workloads, and require staff to adapt to different environments, policies, and processes. NHS staff experience physical and psychological ill-health due to being exposed to multiple stresses over extended periods of time, which can lead to burnout, particularly emotional exhaustion, as the literature showed.

LD staff experienced similar stresses, and some that were characteristic of working with the client group, such as challenging behaviour and working in isolation, and were similarly exposed to occupational stress and burnout. Art therapy practice exposes art therapists to accounts of all the difficulties the clients face in their everyday lives, experiences of trauma and abuse, associated mental health difficulties, and difficulties arising from the learning disability and associated symptoms. Transference and counter-transference processes subject art therapists to powerful unconscious processes, often more powerful because the clients' capacity to express what they are feeling and experiencing is reduced by the learning disability. This reduced capacity contributes to the impact on the art therapist, but also benefits considerably from the efficacy of using art to facilitate emotional expression and processing.

Art therapists employed in the NHS and working with people with LD experience occupational stress from both aspects of their employment. Occupational stress was shown to affect employees physically and psychologically, leading to burnout for some. Only a few non-British arts therapists had written about occupational stress and burnout, most art therapists confined their research to clinical practice and efficacy of art therapy. There was a substantial literature on occupational stress with different professional groups, and NHS and LD studies were discussed and showed that high numbers of staff were affected. Empowering management and supervision were protective against burnout.

Resilience in staff was shown to be a necessary characteristic for withstanding occupational stress, and being able to bounce back and experience personal growth. A key aspect of resilience was self-awareness, which is an expected feature of therapist

characteristics as it is important for understanding transference processes. Creativity was also shown to be healing and restorative, as well as another useful component of therapeutic work, and key to recovery from occupational stress and burnout. Stress management included image-making for art therapists and some psychologist/artists, clinical supervision, research, and general strategies identified through the literature.

Next

The next chapter is the Autobiographical Chapter, which examines my own experience of occupational stress working as an art therapist employed by the NHS with people who have learning disabilities.

Chapter Three

Autobiographical Background to the Investigation



3.0 Introduction

This chapter addresses my experience of the phenomenon I sought to investigate, grounding this heuristic investigation within my personal experience of the research questions, which were ‘what is the impact of the work on the art therapist who works with people with learning disabilities in the NHS?’ and ‘how do art therapists avoid burning out in this context?’

I have worked as an art therapist in one NHS organisation for most of the twenty-one years I have been qualified. For six years, at the start of my time working in this Trust, I worked part-time (eighteen hours a week, over three days) in a specialist NHS unit that provided day care and therapeutic treatment for twelve clients who had severe learning disabilities and challenging behaviour. I also had a second post in a different area of work, in the same organisation, for nine and a half hours per week,

The specialist unit proved to be a source of both job satisfaction and occupational stress for me, but I was troubled because one of my therapist colleagues burnt out and ended up leaving his post, and the organisation did not handle this situation well. Howard’s burnout was painful for me and I felt that I needed to understand it, as well as how I grew from that experience and developed longevity and resilience within my professional role.

The specialist unit had a therapeutic ethos, embracing a ‘gentle teaching’ approach (McGee et al, 1987) to managing challenging behaviour with this client group, aiming

to seek to understand rather than react aversively to such behaviour, thereby reducing the use of physical restraint with the clients. As an NHS unit it also functioned within a medical model, and embraced social role valorisation (Wolfensberger, 1983) as an approach that sought to reintegrate people with learning disabilities into society.

Three teams of support workers were responsible for day-to-day activities with the clients, and each team had a leader. There was an overall manager of the unit, and a team of therapists, of which I was a member as the art therapist, and there were also a music therapist (Howard), a dramatherapist (Carl), a speech and language therapist (Sally), and an aromatherapist (Sue).

I was married with three school-age children between seven and eleven years of age, but experienced difficulties in my marriage prior to and since a recent move from London, and my mother had dementia (she was divorced from my father during my childhood). However, I had many good and supportive friends, and was part of a vibrant church.

The autobiographical account presented in this chapter enabled me to identify the issues relevant to this heuristic enquiry, and was demanding but illuminating (Djuraskovic & Arthur, 2010; Haertl, 2014). A series of twenty-six journal entries from those years, three self-dialogues (created during the analysis of my own data, so later than the journal entries) and seven images illustrate the personal and professional issues I experienced and are discussed in sections 3.1 to 3.3; section 3.4 brings the account of my experience forward to the period in which the participants were included in my investigation, and section 3.5 concludes the chapter. This account forms the background to the investigation.

3.1 Starting Work in the Unit

This section explores my experience as I began work in the unit; I had been qualified for eighteen months and was inexperienced with the level of the clients' disabilities, particularly the severity of their LD, and working there really stretched me. The section has four journal entries, starting with one in the first week and another a month later; then there are two entries after six months, in consecutive weeks. There is also an image I made at that time. The journal entries show how initially I struggled to know how to function but gradually found my feet, and some of the issues we would face in the unit became apparent.

J1: *It's my first week in the specialist unit. I am afraid of getting hurt, unsure how to communicate with the clients, and feel out of my depth. Howard [music therapist] told me that the last art therapist only lasted six months and left because she was afraid of the clients – and he looked at me in a way that seemed to say 'see if you can do any better – we weren't impressed'. I hope I can. I'm glad I got the job because we need the money and the other job is so few hours it doesn't help much, but I'm not sure what I've let myself in for. However my contract is on the band lower than advertised because I haven't been qualified for long and I'm annoyed about that.*

As a Mum I recognise that much of the communication and behaviour of the clients is very young behaviour and I can understand it on that level. As a therapist I have been trained in object relations theory [which is about mother and baby interactions, individuation and child development] and thinking about what I had learnt about that is helping me to think about what's going on. But I'm still not sure how to communicate with the clients.

The unit staff are great, mostly. Peter and Julie [team leaders], in particular, have been very welcoming. George [support worker] is a bit prickly and makes me feel like I'm in the way. I feel rather useless because I feel completely de-skilled at the moment. Howard says I can just mirror the therapists and staff for some weeks, because I have to get to know each individual, as they all have different ways of behaving and communicating. Some, like Susie and Mark, can speak and understand speech quite well but their speech is difficult to understand, and Susie has a very alarming habit of waving her hands in your face like she's going to hit you – the staff just ignore it, but I am not sure I can. I keep flinching.

Some of the clients behave in quite threatening ways, and I have been warned to be careful round Diane because she bites. Tony is always banging on doors and charging about –it's alarming. Jeremy has a nasty habit of grabbing people's hair when you're not looking, and I saw him grabbing Sophie's [support worker] hair and three staff trying to get him to let go.

At the moment I can't see how I can do art therapy with the clients if I can't even talk to them. I guess it will get easier. I'm glad to know my Bible study group are praying for me.

Journal Entry, 12.03.98

I struggled during the first few weeks to find my feet, and establish myself, feeling deskilled and afraid of getting hurt; I was, in fact, truly deskilled at that stage. My life experiences and training gave me some ways of thinking about the clients and their difficulties, but I soon learnt I had to conquer my fear and that it was not acceptable to show signs of it. There was a good general welcome and I was not expected to do too much too soon.

The image below represents my disturbed feelings at the time, but it was not all bad hence the gold amongst the colours.



Figure 11: 'Gold Amongst the Chaos', March 1998

The next excerpt is a journal entry written a month later.

J2: *I'm a bit more settled in the unit now. I get on well with the other therapists – Howard, Carl (dramatherapist – he has only been here 6 months so he's still finding his feet) and Sally (speech and language therapist –she's been here a couple of years and teaches the staff Makaton [LD sign language] which I am learning now). There's also Sue who's an aromatherapist, I'm not sure how often she's in.*

The previous art therapist's notes say she worked with Tony, Roma, Liam, Sarah and Don. They seem to be the clients who are most interested in making art. I am trying to get to know them, but I still haven't tried to do any sessions with anyone yet. I have a basic grasp of Makaton, but some of the clients have their own versions of signs!

Jeremy grabbed my hair the other day and I couldn't escape. It was so painful and Peter told me to keep still, because moving about means you are likely to lose more hair. It took about twenty minutes for Peter, Julie and Sophie to get me out, and they took Jeremy out on the bus earlier than they were going to because it was likely he might do it again. I felt so embarrassed and helpless. I have to be more on my guard to avoid situations like that.

I've been shadowing the therapists and some of the support staff, and I am beginning to learn about each person here, but I feel pretty useless. I've been looking at how to use the oddly shaped art room, and the materials that are in

there. They don't seem very well equipped so I will talk to Edwina (the manager) about that when I see her, she's not around this week. Carl and Howard invited me to walk with them to the bakery to get something for lunch, so that was nice.

Journal Entry 20.4.98

After a month, although still challenged by my lack of experience, I had a better understanding of how to communicate with the clients and had thrown myself into the work with enthusiasm. I also had my first experience of being attacked by one of the clients, and was more aware of the potential danger we faced each day, and became more vigilant. I was receiving training in LD sign language too, which was helpful and increased my skillset.

The next two journal entries are six months later.

J3: *I've just come back from holiday with the family and it was great to have some time away together. It's difficult juggling working and looking after the kids in the school holidays. I have a very complicated chart of who's doing what when!*

Sally and Carl are both away for a couple of weeks, so the unit seems rather quiet. Two of the support workers are ill, and the manager is over at [name deleted] all week, so we are short-staffed. Howard has offered to help escort the bus when they do the home run. I think that goes against our boundaries, so I'm not going to. I asked him about it - Howard said they needed his help so he was going to do it. He didn't seem to think much about the boundary issue.

Tony got very agitated today and had to be restrained and given PRN [sedative], so he didn't come to his session with me because he was too uptight. Howard helped the staff - not having Edwina around was an issue. The staff coped but having two off sick makes it more difficult. I felt awkward about trying to maintain my boundaries.

Journal Entry 15.8.98

By this time I felt more at ease in the unit but was still worried about getting hurt, and not entirely confident in my role because of conflicting boundaries. Issues that would be of ongoing concern to me and my colleagues regarding staffing, management and boundaries became evident. On a personal level, I was managing a complex child-care situation during the long summer school holidays.

J4: *I was in the art room getting it ready for Tony's session, which means moving the tables and chairs round so I can get to the door before he can if necessary. I had to lock the door because he was banging on it - it made me*

anxious, and my hands were sweaty. Then he went outside – I thought that was a good sign until he started banging on the windows!

When he came in at 2 o'clock (his session time) he tried to grab me round the head, saying 'Li – Li' (he can't pronounce 'Liz'). He wanted to kiss me. I asked him to sit down, and he did. Then he used the felt tips to draw big circles, pressing so hard that he made holes in the paper. I was feeling very anxious still for about half the session, and was very alert for any warning signs.

After two images, he chose some shapes to draw round, now much calmer. I stopped feeling anxious. He smiled when he finished the drawing and pointed, saying 'Loo!' (he can't say 'look' either). Then he giggled a bit and waved his fingers about. He stayed in the room for 40 minutes and then said 'finish' and picked up all his pictures and left with them. I wanted him to keep them in the room but he wants to show them to his carer when he goes home.

I was relieved because the session went pretty well, but I need to think about how to keep some of the images in the room and how to protect the felt tips which are getting ruined.

Journal Entry 22.8.98

I had established art therapy sessions by this stage, and this journal entry described a session with Tony: how he communicated, his art-making process, the challenges I had to address and contain, and how it made me feel.

I have inserted the first of three self-dialogues at this point. It provides another perspective on the impact on me of working in the unit. This is a form of self-analysis used in the heuristic methodology (Moustakas, 1990).

Self-Dialogue 16.03.2013

LIZ I was thinking about the *attack on thinking* that the therapist experiences doing work with this client group.

ELIZ It sounds debilitating.

LIZ It is. When I worked in the unit I found that the difficulties the clients had with thinking, understanding and communication *affected me too*. Clients who lacked speech communicated with other forms of communication, such as gestures, body language, signs (some Makaton), facial expression, action, and vocalisations. And *each client communicated differently* so instead of finding myself at an advantage being a person who could speak I found I had to learn how to communicate with each client.

ELIZ What are vocalisations?

LIZ They are vocal sounds made by people. I guess we all do them, for instance when we say 'um' or 'ah'.

ELIZ How did it make you feel?

LIZ It was tiring, *very tiring, wearing*. It was so hard to make sense of what was being communicated to me. It did get easier as time went on, but at first I was completely at a loss about how to communicate in the most basic way. I had to learn all over again and rely on other senses, and cope with so much *loss of my normal capacities*.

ELIZ Whereas your clients had the loss of ever having those capacities?

LIZ Yes, and such loss led to *fear and challenging behaviour* in all the clients at the unit. Because part of their communication was in the form of challenging behaviour (which could be violence against self or others, non-compliance etc.), when it was expressed as violence it was frightening. Indeed I experienced fear every day I worked in the unit, but it had kind of gone underground. No-one in the unit ever talked about it.

ELIZ Then some time later, in another relationship, you experienced it at home.

LIZ What a shocking revelation! I never realised that before. I learned to tolerate too much at work, and then at home I found I reacted similarly [*I reeled in shock for some days while I absorbed that thought, and discussed this revelation with a couple of close friends*]

This self-dialogue shows how illuminating, even disturbing, my experience of self-analysis was, and therefore how useful a process it proved to be. Several themes emerged from this self-dialogue including the impact of the clients' difficulties on my own thinking, the complexity of communication with the clients, my experience of losing capacities I could normally rely on, how tiring the work was, and the impact of ingrained hypervigilance on my personal life.

3.2 The Next Five Years

This section has journal entries from the next five years as I became more experienced working with the client group. Themes and sub-themes become evident in each entry, which I explore in the Findings Chapter (Chapter Four); there are also two self-dialogues and three images.

J5: *I enjoy my work in the unit more now and the other therapists are becoming good friends. I have found ways of working with Tony, Roma, Sarah, Don and Liam, and I understand their communication pretty well now.*

The challenging behaviour is clearly one of the ways they communicate when they can't think of other ways.

It's complex but the unit is run by [name deleted] NHS Trust, who also employ the support staff, unit manager and Howard, and the rest of the therapists and support from the psychology team come from my NHS Trust.

John [my manager] agreed I had proved myself and up-graded my contract to the second increment, so I am very happy about that!

The lack of aesthetic stimulation, because their artwork is at a pre-representational scribble level, is a bit of an issue for me, although I enjoy the colour combinations Liam uses. I am able to give him choice in the sessions, in contrast to most of the rest of his day, and I discovered that he understands the names of the colours so he can pick what colours to paint with by pointing at them. The paintings are lovely wet, but lose their luminosity when dry. He always paints in arcs, covering all of the paper, and never wants to do anything different.

However I am struggling in sessions with the clients because I get bored. I think my problem is that I need more intellectual stimulation than they do. I struggle to stay awake during sessions when the artwork is progressing slowly, is very repetitive and there is little said or vocalised.

Tony is still banging on the doors and windows when I am setting up the room for his session. It still makes me a bit anxious but not so much now.

Journal Entry 27.03.99

By this stage, after a year in the unit, I was established in my practice; I had regular individual sessions with several clients, had become more adept at communicating with them, and had established good working relationships with my colleagues. I was also more aware of the limited aesthetic pleasure I gained from the artwork created by the clients, due to its slow, repetitive and primitive nature, and the difficult counter-transference that I began to struggle with.

J6: *I've been asked to see Susie but she won't stay in the art room. I am not sure how to manage that. I talked to Carl and Howard about it and they are also trying to see if they can find a way of working with her.*

Howard has been working with Diane for quite a long time, and I joined their sessions in the sensory room a couple of weeks ago, taking Sophie's place because she changed teams. Working alongside Howard, mostly using singing and a few percussion instruments (such as maracas) has been a good experience for me of a very different way of working. The sensory room is interesting, full of soft bouncy surfaces (washable!), a sound system and different light fittings – tubes, curtains, and different colours.

I was surprised by how much physical touch there is in the session, but it seems so necessary and so much part of Diane's communication. We have to be a bit cautious because she bit Howard a few weeks ago. We have to become acutely tuned to how we and she are feeling, and have lots of eye contact – very young stuff. We did some training on 'intensive interaction' [Hewett et al, 2011] recently, and found that it's what we have been doing intuitively!

Music therapy seems very well suited to the very early development of the clients in the unit. The most distressing thing for me is when Diane is head-banging and no-one can seem to stop her or soothe her and it goes on for ages.

Journal Entry 12.06.99

As I gained further experience I had begun to engage in joint work with my therapist colleagues, which exposed me to different approaches and skills, and was a useful learning curve for me. I found some aspects of the work evoked intense feelings, and I had become hypervigilant regarding the possibility of me or my colleague getting hurt.

J7: *I hate the feeling I get in sessions that makes me just want to shut down and sleep. It's so pervasive. I have to fight it. I wonder why it's so strong.*

Tony is banging less on the doors and windows now – yay! He doesn't seem so impatient for his sessions, perhaps because I have started giving him a session twice a week. I have managed to negotiate keeping one image from each session, but he takes the others.

We went through a very bad patch in the unit recently because three of the support workers left, and two were off sick. It's been hard to recruit to their posts – they don't get paid a lot, and don't get much training. It's a hard place to work.

I am worrying about [my youngest child] who is being picked on at school and that's in the back of my mind while I'm at work at the moment, though I am trying not to actively think about it while I'm there. I now have power of attorney for Mum [she has dementia].

I took on my first trainee in my other post a few weeks ago. I am excited about that, and I think she can help me a lot with the two ward groups I am running because it's hard doing it on my own. Some of the psychology trainees have helped, and that's been good. The OTs seem to think I am in competition with them - it's annoying.

Journal Entry 3.10.99

The counter-transference had become established and I dreaded it by this stage, and wanted to understand why it was so pervasive; nevertheless, some evidence of the

efficacy of my work with Tony was evident, and that was encouraging. Support staff sickness levels increased and resulted in staff shortages, which made working conditions in the unit more difficult. I also had some problems in my other post and at home to manage but taking on a trainee was an exciting development.

The image below, made at that time, using the medium of tissue paper and watercolour, reflects 'unsettled weather' as it were, but also has hopeful aspects, as shown in the shapes and vibrant colours.

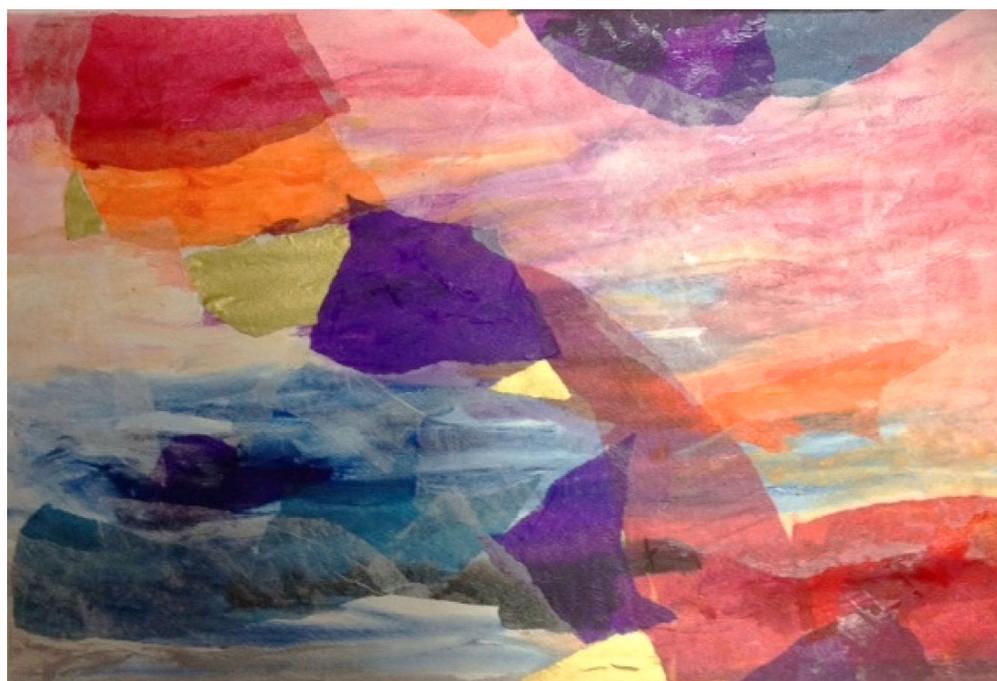


Figure 12: 'Sky-Change', October 1999

At this point another self-dialogue, the subject of which is the impact of the countertransference, provides a different perspective from that of the journal entries, and a greater understanding of its meaning:

Self-Dialogue 24.03.13

LIZ Today I want to talk about the countertransference. I just hated it. This *drowsiness* would come upon me during sessions and threaten to overwhelm me, send me to sleep

ELIZ Why do you think that happened?

LIZ For one reason – *boredom*. The artwork was repetitious, each client had a way of making art and did not want to vary it much. And it was all pre-

representational, so it was hard to make any sense of it or to know if they were using the art to tell me anything.

ELIZ So you couldn't tell if they were?

LIZ No. The assumption was that they weren't because they couldn't think like that.

ELIZ What did they use it for?

LIZ Enjoyment, I guess, as they liked drawing or painting or whatever their preferred medium was. And soothing, containment of feelings. And to engage in the therapeutic relationship.

ELIZ They valued that?

LIZ Yes, Tony banging on the doors and windows was more about the therapeutic relationship he valued than art-making, I think, though there was probably a quality of that which was different in the sessions too – the sorts of materials he would be offered, for instance, and the level of containment I could provide. But he could do art at other times without me too.

ELIZ Did the countertransference relate to the length of time it took for change to become apparent?

LIZ Yes, that's one aspect of it. Because it happened so slowly that it was almost imperceptible if you were up close, and often others would remark on something having changed before you could see it. We went through long periods of feeling stuck before anything changed.

ELIZ That must have been frustrating?

LIZ I remember it being frustrating and wearing. I had long patches of feeling low that I had to weather, feeling useless and deskilled. It felt sapping.

ELIZ Why do you think you felt useless when you were clearly gaining experience and doing well in the unit?

LIZ I think it's a powerful countertransference from the clients – they feel useless and push it into the workers

ELIZ That's a hard dynamic to cope with all the time

LIZ Indeed it was. And the artwork mostly lacked aesthetic enjoyment for me, apart from Liam's paintings, which I enjoyed for the colours he used and the luminosity of the paint when it was wet.

ELIZ So there was a limited amount of aesthetic enjoyment?

LIZ Yes, but they lost some of their beauty when they dried, sadly.

ELIZ What else related to the issue?

LIZ The lack of intellectual stimulation was probably the main cause of my feelings of boredom. The clients' necessary level of stimulation was considerably less than I was used to and found I needed.

ELIZ What did you do to combat that?

LIZ With some clients I made drawings in the sessions with them, and that helped me to stay with the silence or the repetitive mark-making.

ELIZ Why was there silence?

LIZ Most of the clients lacked speech, although they vocalised at times, there would be long periods of silence if they were sitting making artwork.

ELIZ How did the countertransference feel?

LIZ Like a blanket that would come over me and force me under. I wanted to lose myself in sleep or nothingness. I read about a nihilistic counter-transference in Rees (1998b), which related to clients' sense of not being wanted, fundamentally, since birth. Rejection. That was the only place I think I have read about it. The blanket would descend session after session, and I had to fight it; I hated those feelings.

ELIZ They do sound hard to cope with.

The impact of different aspects of the countertransference on me was considerable and the self-dialogue enabled me to think about it retrospectively and gain some understanding of its origin. I found that articulating the impact was very helpful to my thinking, through writing, through this form of self-analysis or in supervision.

The next journal entry marked two years of working in the unit.

J8: *Amazingly I've been at the unit for two years now. Carl and Howard tease me and call me 'mother superior' because I've been trying to get them to be more organised! We've been writing reports on our sessions, and Peter and Julie pointed out how calm Tony is now waiting in the reception area for his sessions! It happened so gradually I hardly noticed.*

Howard and I are doing joint sessions with Susie, combining art and music. It's a bit of a struggle. I still can't cope with her waving her hands in my face as if she's going to hit me. She sings 'Three blind mice' a lot, and as there are three of us in the sessions it seems quite appropriate! How blind are we?! She took my glasses off the other day and threw them on the grass - we were walking in the park with her; fortunately she didn't break them.

Sally (SALT) has started doing a behavioural intervention with her designed to get everyone in the unit to behave differently with her, in order to change

her behaviour. One of the things is to look her in the eye and say good morning to her– surely that’s obvious?! But apparently not to everyone!

Dave, the behavioural specialist in the psychology team, did some good sessions during the training days we had and the newer staff understood ‘gentle teaching’ better afterwards. All of us [therapists] did training about why we need boundaries, what we are trying to do with the clients, and what we need them to do to help us.

Since our 20th wedding anniversary I have been wondering how long I can cope with my marriage because I’m aware there are warning signs that [my husband, name deleted] might be starting another affair. I am struggling with that, after all our counselling [over a two-year period, prior to our move from London].

Journal Entry 11.04.2000

By the two-year point of my work in the specialist unit joint working had become a normal approach and the therapy team was a close-knit partnership; we also worked a lot with Sally. Persistent maintenance of my boundaries had resulted in obvious progress with Tony, and training with the staff had been necessary to ensure they understood what the therapies could achieve and what support we needed to make that happen. Personal issues I was worried about were more apparent too.

J9: *The OA psychology team had to move offices away from where the LD team is based, which is rather inconvenient for me. I decided to keep my admin stuff with the LD team because I am there more. I am doing some locum work while Mary, the other art therapist, is on maternity leave and that’s giving me six more hours, which I am pleased about. I am getting to know the staff in the LD team better because I am around a bit more, but I see less of the OA team, and that’s the trade-off unfortunately.*

The locum work is going well, and the clients are less cognitively impaired than those in the unit, so I am enjoying that. I have been asked to take on a young man who is a fire-setter as they resettle him into the community – I hope he engages with me.

At the unit Carl, Howard and I have lunch together a lot when we are all in and we have been trying to find literature about work with our client group. But we haven’t found much yet apart from the art therapy book that came out a couple of years ago (Rees, 1998).

I’m struggling with the noise in the unit, smells from food in the art room and mess left on the floor. There are too many people in the building and it really doesn’t work well with therapy. I really think that the building is not suitable or big enough for daycare activities and therapeutic sessions in the one space.

My supervisor Carol is great, and she has helped me to think about aspects of my work in the two teams. I hope I will still be able to see her when her job moves. John hasn't been very helpful in my managerial supervision sessions, I think he's got some stuff going on at home that he's struggling with. I also talked to Carol about the divorce.

Journal Entry 17.09.2000

Organisational issues due to moves between buildings within the NHS Trust had to be adapted to, resulting in more complex work arrangements to manage between my two posts, and less contact with one of the teams. Issues in the unit due to overcrowding and the space not being suitable for therapy were becoming apparent, and at home my marriage was heading for divorce, so there were a combination of stresses building up from different sources that I had to manage.

More positively, the therapy team were trying to think together about our work and to consult the literature, and I gained some locum work, which exposed me to less disabled clients and benefited me financially.



Figure 13: 'Branching Out', November 2000

This image was created towards the end of my second year in the specialist unit, and is about trying new methods in my therapeutic practice, including starting locum work in

the main LD department. The black and white palette and printing process have resulted in quite a fragmented and stark image, reflective of my feelings at the time, affected as they were by increasing stress from multiple sources.

J10: *I am doing joint sessions with Howard as I was so stuck with Tony, and Carl was stuck with Eric so we are trying a joint approach to that too. Both are art-based sessions in the art room. With both there is a male-female therapist dynamic, which I think could be useful from a developmental point of view. Tony and Eric have both accepted the new way of working, though I still do a 1:1 session with Tony as well. Howard is too tied up to do both sessions.*

Jeremy tried to barge into the room during Tony's session today, fortunately the door was locked, but he created a lot of noise in the process, which was very distracting. It wasn't helpful because Tony needed some quiet to help him settle.

Mary is back at work and John was so pleased with my locum work that he asked if I would like to have the six hours permanently added to my contract! That's so great! I'm nearly full-time now, with both my posts. I see more of Mary now and I am enjoying getting to know her. Also I have been asked to supervise an art therapist who has just qualified and is working in another area in the Trust; that's another encouraging development!

There's talk of the mental health unit being knocked down and re-built, but we don't know if there will be an art therapy studio in it. There are four of us using it so it will be very difficult if there isn't – we discussed how to manage that.

Journal Entry 24.1.01

Three years had passed and in this entry there was evidence of professional development in different aspects of my work life, resulting in financial and relational benefits, which were very positive. At the unit the gender mix of therapists was proving helpful in our joint working endeavours, but there were session interruptions. However, there were organisational changes that we were afraid would have negative repercussions for us in my other post.

J11: *All of us in the therapy team [at the unit] feel like we're hitting our heads against a brick wall. We feel angry and frustrated. There's too much restraint happening in the unit, and too many staff off sick all the time. There's also too much noise during therapy sessions and too many interruptions – and sessions getting cancelled. I talked to my manager about the situation but he can't do anything because it's the other Trust's responsibility. Edwina has resigned and no-one has been appointed to manage the unit yet, so we are in limbo. Peter and Julie are really fed up.*

Edwina was never there much and they had to do a lot on their own but they haven't had this situation before. Hazel now has to cover three units because they have to have someone in charge, but she's not well.

I only did three sessions last week because the clients kept being taken out when they shouldn't be. Why do we bother having timetables?

I went to the library to find some stuff to read about working with people with challenging behaviour and I found some references, so now I've got to track the papers down. Dawn the librarian was very helpful, but there doesn't seem to be much out there.

Carl talked to Howard and me about a problem with his girlfriend. That's not going well. Howard is worried about his asthma - the cold doesn't help him especially when it's damp.

John has said I can have some new art materials, so I'm pleased about that because I am running really low.

I'm going to see Mum in her residential home next week and I try to see her every month, although it's a journey of over 200 miles; I have arranged to stop at Dad's on the way, so I get to see him as well. Had to go to the GP yesterday about my stomach pains and bleeding.

Journal Entry 13.10.01

Management of the unit had reached a crisis point, resulting in staff sickness because of the pressure on remaining staff, who had too many roles to manage on top of their normal responsibilities. Our sessions were being impacted badly. I had also begun to experience health issues. The organisational split as a result of two organisations having input into the unit was evident, and was not helpful, or apparent to those concerned. It was a difficult period of time, and the therapists in the team all had personal pressures to cope with, in addition to the impact of the situation on their work.

J12: *The fire-setter went AWOL even though I warned Hazel that might happen after his favourite support worker left. It's not good because he could have got into an awful situation being as vulnerable as he is; fortunately the Police found him. Ryan [another client] is very traumatised and very vulnerable too; but he's coming regularly and using the sessions well.*

The new hospital building is under construction and there's not going to be an art therapy studio. We're really upset about that. We're having talks with our managers about what to do. Jacky [one of the other art therapists] decided to leave and we're very sad to see her go (and they won't replace her post to save money). We will have to run sessions on the wards, and they say there will be suitable rooms - we'll see how that pans out...

Tony drew a stick person this week! He's never done that before. The sessions with Howard have been going really well, and it's like we're the parents he hasn't had. We've concentrated on the dynamics between us, sharing, and so on. He likes me to watch and be attentive to him, and interacts more with Howard. It makes me think of the importance of the mother's gaze in baby development.

I had an appointment to see a consultant gastroenterologist and have been told I will have to have a sigmoidoscopy [scan of lower part of the colon]. I don't like the sound of it.

Journal Entry 04.04.02

Four years had passed and my therapy sessions in the main LD department were well established by now, and sessions in the specialist unit were reaching a new level of engagement that was encouraging. However, in my other post, the mental health unit re-building project resulted in the loss of the art therapy studio affecting me and the other art therapists, and one of the art therapy posts was also lost; it felt like a backward step. My health issues appeared to be serious, so although my LD work in both areas had settled down and was again progressing, the impact of all the combined stresses I had been managing continued to impact my physical, though not my mental, health.

J13: *I decided to study for an MRes and just enrolled. John has agreed to pay the first lot of fees, and to give me ½ a day a week for study leave! He says he can't guarantee to pay the 2nd lot of fees but I can ask. I had to do a research proposal and I decided to do a survey of art therapists working with people with severe LD and challenging behaviour; I'm hoping to find the answers to some of the questions Carl, Howard and I have been talking about and struggling to find.*

The unit is having another training day next week, and Carl, Howard, Sally and I were discussing what we need to do. We are still having problems with the staff respecting our boundaries, and if they don't how can they expect the clients to? We're still struggling with noise and disturbance during our therapy sessions. One of the problems is the high turnover of staff, so we have to keep re-educating them, but at least the few staff who've been in the unit a long time really understand what we're going on about. Howard helped them out on the bus again this week because of staff being off sick, but I still don't think that's a good idea.

Carl is seeing a therapist, he told us today, and is finding it really helpful. He does seem brighter these days. He split up with his girlfriend, but is in another relationship that's going better now. I am worrying about the children because the relationship with their Dad is not going well.

We're all struggling again, particularly with the counter-transference, the one I hate. It seems to be nihilistic and I read an awful chapter in a book about the hatred learning disabled people experienced in the past when they were

shut away in asylums for their whole lives. It really upset me. Jeremy got my hair again this week, and I lost a chunk of it; it hurt a lot. He's really upset about something, probably at home as we are aware there are problems.

Journal Entry 11.10.02

I continued to press on with my personal development and fortunately was supported by my manager to do so, rewarding me as evidence of his appreciation of my work. I hoped that my studies would benefit our work in the unit by providing me with further knowledge of the issues we were addressing, and the difficulties with thinking in the unit meant that another source of expertise was needed to help us develop our work.

High turnover of staff in the unit meant training had to be repeated – an ongoing scenario - although the few longer-term staff were extremely valuable in the unit because they understood our approach, and because the clients benefited from their presence. The building was not suitable for therapy sessions, as was becoming more apparent. Carl and I both had personal issues to cope with but Carl had sought therapy, which was very beneficial. I suffered another injury at the unit despite the habitual hypervigilance that we all maintained.

J14: *The MRes is going well and I just handed in a literature review on addiction, which was interesting and I had to do a presentation about it. I am enjoying studying and I've made friends with my fellow students on the course. I also made some artwork while I was at college.*

Howard's asthma was better controlled before but not so good now. He won't take any time off though. The unit is struggling with staff shortages again and he feels he is needed too much there, and because he works for that Trust he feels it's his duty. They always ask for his help when they are struggling with an incident because he doesn't mind wading in with them. I still feel it's against my boundaries, so I don't - I get too scared, though it wouldn't be well received if I admitted it. Carl, Howard and I are really fed up with the situation and talked about moving out of the unit and setting one up elsewhere, which would mean we could see a wider range of clients too, as well as addressing the issues in the unit.

Doing my OA groups on the wards in the new hospital building is just not working. The ward staff keep interrupting my sessions and the room is filling up with all sorts of junk so there isn't enough space any more. I asked Marian [OA boss] if I could stop my groups and just do individual sessions if I can't find an adequate solution to the problem – she said I could. I don't want to go into work and when I feel like that I know I need to do something about it.

Journal Entry 14.03.03

Five years on and many stressful issues are evident in this entry in both work areas and at home, and Howard was unwell. Issues in the unit were recurrent and the therapists were at a stage of wanting to leave, and likewise I wanted to stop working on the wards in the mental health unit in my other post and was seeking a solution to that problem. However, my studying was going well and provided a beneficial thinking outlet, and contributed to my personal development; thus it helped me cope with the combined stresses despite (or perhaps as a result of) requiring energy in a new area.

Below is a third self-dialogue, which again gives an alternative view of the impact of what was happening in the unit, particularly in relation to fear, and discusses powerful feelings in the unconscious material, proving it to be a useful analytic tool:

Self-Dialogue 12.3.2013

ELIZ What aspects do we need to talk about today?

LIZ There's the *feeling of uselessness and being deskilled* that's *so pervasive* in the unit – and thinking was so hard for all of us. Perhaps hardest for the support staff because they were not trained to think about meaning in everything in the way the therapy staff do... We all felt so crap, like we couldn't do anything, change anything – everything took so long...

ELIZ What do you mean 'took so long'?

LIZ Change in the clients came about in such *small incremental steps*... like after a year and a half of art therapy, and maintaining my boundaries the same all the time, Tony learnt eventually to wait calmly for his session in reception instead of banging on the door and windows while I prepared the room

ELIZ That must have been quite alarming?

LIZ Yes it was at first, but I got used to it. Like I got used to having to pretend I was unfazed by Suzy making aggressive hand movements in front of my face as if she was going to hit me, but didn't – I found it so hard not to show how that alarmed me but aside from the time she removed my glasses she never did hit me, so I got used to having to deal with it

ELIZ Why did you have to pretend? Couldn't you just say it wasn't ok and stop it?

LIZ I tried that to begin with

ELIZ You are talking about fear in the unit?

LIZ Yes, I did experience (and had to tolerate) a lot of fear in the specialist unit.

ELIZ What did that do to you?

LIZ I think hyper-vigilance became a way of life, which included thinking about what one wore, how one arranged the furniture for a session with a particular client so you could get out quickly etc.

ELIZ Did fear ever get talked about in the unit?

LIZ No. And it never occurred to me or the therapy team to talk about it either, which in retrospect seems incredible.

ELIZ That shows the extent to which it became completely ingrained... what was that about?

LIZ Perhaps it was a defence against punitive feelings, which are the normal reaction to violence against one's person. In that sense it's counter-intuitive.

ELIZ But they did use some restraint, didn't they?

LIZ Yes, physical and pharmacological, but the emphasis was on gentle treatment as a first reaction. And for therapists thinking about meaning.

ELIZ The *context* also had a bearing on the impact, did it not?

LIZ Yes, because the unit was so noisy, and chaotic, and our boundaries kept being violated in so many ways that we were constantly having to reinforce them. The clients didn't understand boundaries and the support staff seemed unable to think about them either. Difficulty thinking again, I suppose.

This self-dialogue addressed the very significant impact of the work in terms of the feelings it evoked, everyone's impaired thinking, fear, and the lack of awareness or dialogue about this dynamic in the unit. Hypervigilance, fear of and exposure to violence can result in PTSD, so is a dynamic that needs to be talked about in units where this is a regular feature in order to protect the staff from the possible impact on their mental and physical health. Supervision should be offered to such staff too. Of course I did have supervision, but the dynamic had gone so 'underground' that I was unable to think about it until I started to analyse my experience.

J15: *I talked to John again about the problems at the unit, and this time he suggested that we talk to the commissioner; he is going to arrange a meeting to talk to them. Sally is leaving next week and it feels like a terrible loss. The latest manager has recently left and only stayed for a year. The support staff are doing a great job, but Tony's behaviour has become challenging again and they have had to restrain him a lot. Dr. [name deleted] is coming to increase his medication and see if that helps. Our sessions have become more tense again, he's not staying for the full session time, which would have been unheard of a year ago.*

I've got several individual clients now in my OA job, so that's going well. However all the psychology departments have to move soon and there are lots

of talks going on about that, and what's needed. I hope this will be a more positive move.

We went to Liam's funeral last week. It was very sad and the suddenness of his death was shocking. I offered his images to the family but they asked me to keep them. I sat with Tony and a support worker to try and help him cope with the service; it wasn't easy but he did well. Not all the clients were able or allowed to come, so not all the staff could. But we had lots of talks about how to communicate death to them, and it has to be out in the open, not hidden, because how else can they understand and cope with it?

The house move went well and the family situation is more settled. However, the children no longer have contact with their father due to events beyond my control. I am shocked, sad and angry about that. My colitis is really bad at the moment but I still am managing to go to work, although the nausea can be hard to cope with.

Journal Entry 30.10.03

After years of seeking assistance from management regarding the issues in the unit we finally had some positive input, but not in time to prevent important staff members leaving including Sally, which made us very sad; however, we too were thinking of leaving and re-locating elsewhere. The unsettled situation was reflected in clients' behaviour, and a sudden client's death created another situation that needed our input to ensure the clients were helped to understand what had happened.

Within the organisation there was another move between buildings being negotiated, and there was anxiety within the departments about how that would impact our work and whether it would prove to be beneficial.

My personal situation developed considerably in both positive and negative ways but still very stressful, and it was badly impacting my physical health.

J16: *Mum's health has deteriorated badly and she looks almost skeletal. She thought I was her mother when I went to see her. I don't know how she survives in that condition and I think she must have cancer or something, but her dementia is so far advanced that they can only give her pain relief now. It's so distressing.*

The MRes is getting to a crucial stage. I am writing up my dissertation now, and got a fantastic response to my questionnaires.

The talks at the unit have resulted in lots of positive decisions having been made, such as better pay for the support staff and better training. We are

moving out of the unit in June, and a new therapeutic unit will be provided somewhere in the area, which is exciting! We are so looking forward to moving to a more conducive setting for our therapy sessions!

John says that while the new unit is being set up we need to sort ourselves out and develop caseloads in the main department, as we can't work with people with severe LD and challenging behaviour in that setting. Howard will move over to our Trust, which will make things easier. John's very busy as he's acting director and can't give us much input, and Mary and I discussed possible leadership for the arts therapies with him. Carol has been very helpful to me during this time.

Journal Entry 5.4.04

My mother seemed to be dying, which was hard to cope with as I neared the end of my course and had to cope with the pressures that brought. My MRes research yielded the hoped for knowledge and results just as we were making plans to leave the unit, ironically. After six years in the specialist unit I was ready for a new challenge, which appeared to be moving towards the establishment of a new therapeutic unit. We hoped to continue our work with people who had severe LD and challenging behaviour in a more conducive setting armed with my new knowledge, though a time in the main department was necessary while it was being set up.

The image below reflects my feelings at that time. The right side of the image is more settled and the strong colours suggest happier feelings, while the left side of the image appears more disturbing, and possibly even malevolent. Thus the image reflects the balance of negative and positives aspects of my life at the time.



Figure 14: 'Stress amidst Good News', April 2004

3.3 After Moving Out of the Specialist Unit

In this section there are six journal entries, and one image. During the previous six years in the unit Howard had been highly committed to his work and rarely off sick even when unwell, but following our move into the main department the situation began to unravel. Though Carl and I established new ways of working Howard struggled to, and this section shows what happened, leading to him burning out.

J17: It was very strange not going to the unit every week after we moved out. We were welcomed in the main department and Carl, Howard and I meet regularly to discuss potential developments for our new service, though not much has happened in that direction yet. I guess it's early days.

Rooms are hard to find in the Trust. Carl surprised us by getting a job in CAMHS in addition to his LD job, and he has negotiated to see LD children in his room there, in the absence of space in the main department. Mary and I are sharing the small art room in the LD department, which is difficult but we are managing. Howard is finding it hard to establish music therapy because of the lack of a suitable room.

Agenda for change is making everyone worried about their jobs and rate of pay. We all have to translate our job descriptions and person specs into KSF speak and submit them to the A4C team. Carl is on the team. John has decided to make me and Mary joint leads for the arts therapies (amazing!), so that alters our job descriptions; he can then devolve some of his managerial responsibility to us. We have several trainees this year, and Howard and Carl, plus two other art therapists will be under our line management and supervision. We are both worried about Howard, who doesn't seem to be coping well. We discovered he hasn't had a clinical supervisor for years, but doesn't seem to have challenged that - appalling. Not sure why.

I managed to submit my dissertation to college on time – phew! I passed my MRes OK, and learned a lot in the process.

A week after handing in the dissertation Mum died. It was both a relief and devastating; I had a lot to do organising the funeral and contacting everyone. My back went and I ended up having to have another two weeks off sick. I had some prayer ministry, which was really helpful.

Journal Entry 14.10.04

Howard was struggling to establish his practice in the main department for practical reasons, though Carl and I had both found good enough solutions to our problems. The nationwide NHS changes to wage structures were causing uncertainty and anxiety, but

the concurrent promotion was a great boost to my confidence and financial stability. Mary and I hoped we could help and support Howard to find a way forward.

The death of my mother had a considerable impact on me, just after finishing the MRes, and resulted in a sickness reaction, which had the benefit of giving me time away from work while I was grieving and busy with related duties. I noticed that while I could cope emotionally with situations, and sought appropriate support to do so, I could not control the impact on my physical health.

J18: *We can't seem to get anywhere with the new therapeutic unit, as none of the places we looked at have been any good for various reasons, and the Trust has decided to sell the site that we thought was the best option. We are not meeting as often but when we did last week we realised how much we missed our lunches and laughs together.*

Carl and Dave are doing joint sessions in the CAMHS room, which our psychology colleagues are interested in; Carl has had a paper he wrote about some of his work with a client in the unit published in the dramatherapy journal, which is exciting. I am going to the AT LD SIG next week [art therapy learning disability special interest group] and I always enjoy the networking opportunities I get there. It's great to see art therapists from other places.

A room has been identified for music therapy but it needs sound proofing; the deputy manager of the department has been working with Howard on this, so that is at least a move forward. However, Howard hasn't followed up on some of the assessments he's been on, and his timekeeping has not been good. His asthma seems very bad at the moment but he doesn't seem to be taking any active steps to look after himself. He says he's OK but I don't think he is. Now we are leads Mary and I have been able to increase our support of him, but he's not responding to any of our suggestions that might help – we're worried about him.

Journal Entry 23.01.05

Plans for the new therapeutic unit appeared to run aground, and soon after it became apparent that it would not materialise due to the NHS purchaser/provider split that had recently been implemented by government; the commissioning arrangements changed as a result. Consequently, our team had had to adapt our practice considerably, and find our own practical solutions to problems we faced; Carl and I were managing well with that process, probably because we had previously been employed by the Trust and therefore had greater knowledge of its processes and staff.

Howard, however, missed our close group, and was unwell; although a room had been identified it would take time to get the necessary works done to make it functional. Howard by now did not seem to have the necessary energy or insight to seek appropriate support; he ceased to fully engage at work, and although Mary and I were able to support him better in our lead roles it seemed to be to no apparent avail.

J19: *Mary and I did well with A4C and got good bands – for me that was quite a wage rise. Art therapists in other areas of the country didn't do so well and are very upset, and Carl tried to get a higher banding, arguing he was the lone dramatherapist in the Trust, but he didn't get it so he was cross about that. He's thinking of doing a PhD.*

Dr. [name deleted] asked me to do a presentation to staff about my work with the fire-setter, as it had been so impressive – it's great to have such a response! Mary and I have too many referrals at the moment so we have a bit of a waiting list. Ryan [one of my individual clients] has gone missing and all the staff working with him are very worried; they haven't seen him for a fortnight. I'm very scared for him.

Howard has been off sick for a week and has not been coming into work some days, and we don't know why. Mary and I talked to him about seeing a therapist. We have explored whether some training would be helpful for him but he didn't have any ideas of what might be useful. Some of the psychology staff are beginning to lose patience with him, as he hasn't responded to their attempts to help him. I suggested he went to see his GP, but I don't think he did. Perhaps he's depressed. He says he's OK at home and still involved with music for church and his choirs.

Journal Entry 12.4.05

Agenda for Change resulted in wage rises for all the therapists but Mary and I achieved higher bands than Carl and Howard due to our added responsibilities; nationwide the picture was not so good and there was unrest amongst professional groups within the NHS. I also received recognition for some of my work within the community team, but a missing and vulnerable client was worrying, and we feared for his safety.

Howard's attendance, time-keeping and performance at work were becoming erratic and causing concern, and none of our or others' attempts to help were acted on.



Figure 15: 'Out of Chaos', June 2005

This image celebrates exciting aspects of my life, which were intermingled with times of difficulty and distress. The rich colours are beautiful but there is a sense of danger within and chaotic elements in the marks above, reflective of recent events.

J20: *The situation with Howard has become very serious. The signing-in book shows that he has hardly been at work in the last month, coming in late and leaving early. He seems unable to get his act together and HR are talking about disciplinary action. I am beginning to think he is suffering from burnout, but no-one in the Trust, even in the psychology department, has any understanding of the condition. I am reading up on it. Next week HR have asked him to come to a meeting with me and Mary and someone to represent him.*

I talked to Carl about it. We are both very worried for him. I am frustrated because he does nothing about everything Mary and I suggest. I think he misses the structure and routine of the unit, and he hasn't found his feet here.

It has become clear to us recently that the new unit is not going to materialise. There has been a change in the rules so that the commissioner and provider arms of the NHS can't talk to each other now, and the commissioner who led the changes in the specialist unit has left. So there is no-one to champion our cause. That part of our work has gone. In some ways I am relieved because it took its toll on me, but in other ways it is sad to lose all the expertise we built up during our work there.

The other day Ryan's body was found in a waste ground some miles from his home. I hope he has found peace at last, but I am devastated thinking of the trauma he may have suffered before his death. There will be an inquest but my colleagues think it likely he was abducted and killed.

Journal Entry 14.6.05

Howard's condition deteriorated and he had become incapable of acting for himself or thinking about his situation. Although I (and the department) had no knowledge of burnout I had started looking into it, and had concluded that this was the root of the problem. HR inevitably became involved and disciplinary action began, and he was advised to go off sick or improve his performance, otherwise his job was at risk. Concurrently Carl, Howard and I had to come to terms with the loss of our dream for the new unit, and we all felt very let down by the organisation.

Our worst fears for the missing vulnerable client materialised, when his body was found, and I was very shocked and sad about that too.

***J21:** The meeting with HR [human resources department] took place. Howard is clearly not well and is in stage one of the disciplinary process because his attendance and performance has been so poor. I took Howard aside after the meeting and told him he must see his GP, and consider going off sick for a period if he can't cope with work, and thank goodness he did.*

Howard's GP has signed him off for three months, which looks like a good thing. I hope the time away from work helps him recover to some extent. I am very sad it has come to this.

Journal Entry 21.6.05

Long-term sickness, disciplinary action and a lack of capacity to act for himself were issues evident here, and my friendship with him at least meant he heard my advice and acted on it. It was a relief that he was now under the care of his GP, but burnout was still not being considered, either by HR or by his GP. I do not think they had any understanding of this condition, or any processes by which they could act compassionately on his behalf. He had become a liability in the Trust, a troublesome employee.

***J22:** Howard has resigned on the grounds of ill health. He has decided to move to Scotland with his family, as he has been thinking of that for some time. I do hope it works out for him. What a terrible time he has been*

through. I think leaving work is the best thing for him, but I hate that it all got so punitive at the end - I don't understand why they didn't get that he was burnt out. I have been thinking about how it could have been prevented, but I think that because Howard himself did not seem to be very self-aware it was hard for us to do for him what he needed to do for himself.

He was such a good friend in the unit, all this has horrified and hurt me very deeply. I wonder if any good can come of it?

Journal Entry 24.10.05

It was a sobering lesson to learn: that this situation could happen to any of us who become worn out by our work, and that, if we are too unwell to have adequate insight into what we need to help us recover, we could find ourselves in this ignominious situation.

As a small team we had experienced some very difficult situations in the unit, since leaving it, and subsequently. Our work situation had changed beyond all recognition, although I suspected that it was to our benefit that we did not resume our work with severely learning disabled clients who presented with challenging behaviour. It had been very demanding and we had all experienced personal difficulties in addition to the demands of the work (mine perhaps being the most challenging), which combined to reduce our energies and resilience. We had succumbed to illness at times. However, I had bounced back over and over again, Carl had too, but Howard eventually had been unable to.

My reading suggested to me that there it was appropriate to work with people with such severe conditions for a few years but not indefinitely, because of the impact on the clinician (Kirk, 1999). I felt that was right for us.

The next section in this chapter considers what was happening in my professional life some years later.

3.4 Restructuring in my NHS Trust

This section addresses the impact of restructuring processes in my Trust as I was working on my PhD, at the same time as I was interviewing my participants, seven

years after Howard left his post. Carl had also left, but Mary was still working with me, and I was still employed in two posts.

John had retired and been replaced by Joy, and Marian was considering retirement, as were all psychological staff at that stage of life, as they did not want to be party to the changes afoot. It felt like quite a blow.

This section has four journal entries spanning one year that document some of the organisational changes I experienced during a period of intense change in my NHS Trust.

J23: *The Psychological Services Review has reared its ugly head again, and we're not impressed because it's been going on for over a year already. We're afraid it will mean job losses, and the major re-structure that they are planning is going to turn the entire organisation upside down. They're doing a time and motion audit now, monitoring what we do every fifteen minutes of the working day, and we have to do that next week. As if we didn't have enough to do in our jobs and getting all our electronic contacts on the new system, which keeps breaking down.*

The new IPUs [integrated practice units] they are proposing will restructure all the departments into multi-disciplinary units rather than in professional groups to avoid 'silos'. It looks as though LD services (except the forensic unit) will stay intact in one IPU, but OA services will be mixed between at least two IPUs and different sites so I don't know what that will mean for my OA post. Mary is worried about her AMH post too. The newly acquired [area name deleted] part of the Trust also needs integrating within that structure.

We have been told, in LD services, that we have to move to another base in about three months' time. It's getting silly – this is the fifth move of base I have had and I can't see how it saves them any money. It's very confusing for the clients too, though not so bad if we can keep the same phone number. But it doesn't look like there will be any clinical space there, so that's another hurdle to negotiate.

Journal Entry 24.06.12

This journal entry shows how much organisational restructuring was being proposed within my organisation at the time, and how widespread it was, affecting all services in the organisation. There were moves between buildings to reduced spending on estate holdings, and the organisation was also auditing their staff's productivity, and introducing new electronic systems for recording contacts. We were feeling some

anxiety about the future because our senior staff appeared to be leaving ‘the sinking ship’ and we were unsure whether our jobs were under threat.

J24: *The organisation of the IPUs has been published – it’s a consultation but we don’t believe they will take much notice of what we say in response. As expected LD services will stay in one IPU so there won’t be much change there, and that’s great news. It looks like our new base is with the whole community LD team, so that’s looking positive. And our LD jobs seems safe. Phew!*

But they are going to get rid of my OA job! Bastards! The list for psychological services shows me and Mary as minus signs alongside our posts (not our names – we’re just numbers to them)... A few others are affected too. So now we don’t know what to think because we have been told that there is no redundancy money and we are on permanent contracts. The department has contacted the union and arranged for a meeting.

Our teams have arranged to go out for lunch for a bit of solace bonding! And the psychology leads have arranged to meet out of office hours at their homes to discuss a strategy for opposing the consultation, apart from stating the obvious in their response.

Dan [my eldest son, who was at university] is moving houses and going to one that doesn’t have any damp with some of his good friends, so I am less worried about that. I hope they can move their possessions without me having to drive up there to help, but Dan says he needs some money for the deposit. The change in the bank base rate has pushed my mortgage payments up too. Mary is worried about paying her bills if she loses her post – so am I.

Journal Entry: 13.11.12

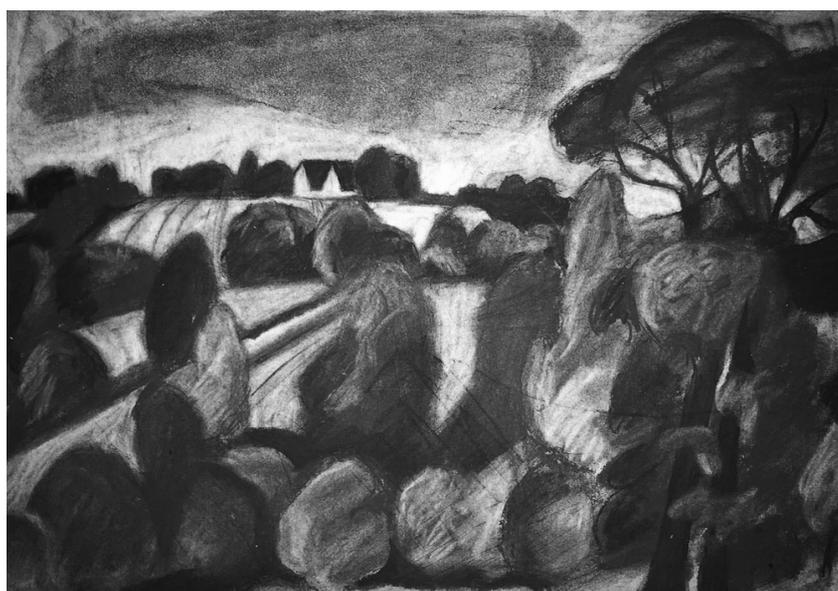


Figure 16: Dark Landscape, December 2012

A tense period in the organisation emerged as it began to organise for the major restructuring, and although my LD job was safe my other post was not and was destined for liquidation it seemed. The image above was drawn during that time, reflecting the mood and uncertainty in the choice of charcoal on cartridge paper as the medium. As a single Mum, my children were still somewhat financially dependent on me, although only one was living at home at the time, so a drop in pay was going to prove hard to cope with if it came to that, and was a source of considerable anxiety. Different LD services were going to be co-located together, so that was an improvement.

J25: *Marian has saved our jobs, and we are both moving to acute psychological services - and she's retiring. She argued that art therapy was needed on one of the wards that is on special measures where my trainees are running a group - and that's what has saved our posts!!! Thank goodness I took notice of Jill when she asked me to consider providing a group for that ward!*

It is such a relief, but we can't do any joined up working in the community like we used to, which doesn't make much sense of an integrated practice unit! Our new boss Stacey seems very nice, and we have met her to try and begin to work out how to close down our current work and move over to the acute service. I don't want to do just acute work, I really liked being able to move between acute and community services and it made more sense for acute patients who still need support when they leave hospital. The main problem seems to be the few hours Mary and I have between us, and the number of acute wards that need art therapy. They are thinking of keeping us only in older people's acute services, although they are spread over three sites.

The LD move has been good, although we are still in a mess. I am thinking of leaving my laptop in my bobby box so I don't have to keep carrying it around. Hot-desking means we will be organised in hubs, it seems, but anyone can work in any space if need be. It's amazing because they have co-located us with the social workers too, so now all the professionals are in one place, and that makes a lot of sense. However, our clinical rooms in the health centre are being closely monitored to see how much we are using them. We can't function without them so that's a worry.

Dan's move went well but Tracey [my daughter] is not happy in her placement up North, so I promised to go and see her next weekend. The probiotic the consultant prescribed seems to be working really well and I am not having any symptoms of my colitis now! I am really happy about that.

Journal Entry: 22.03.13

There was such relief and delight that our jobs had been saved, and Mary and I were very happy after a tense few months of job insecurity. We would have to adapt our

practice to accommodate new demands including agile working, but at that point the specifics had not been ironed out. LD services were thriving and the move of base seemed better than expected, surprisingly; there was a threat to our LD clinical space that we were concerned about, however. My physical health had improved and was stable, and my children were working towards independence with a little help from me.

J26: I am upset because the art therapy group I have been running for seven years for people with dementia will have to end, and the patients are very unhappy about it. The last group will be in four weeks and then they will have no art therapy provision, and the organisation is completely oblivious to this fact. We are organising a focus group to collect the patients' and their carers' views on their experiences of the art therapy group, and one of the psychology trainees will transcribe the recordings and turn them into a report. I am wondering whether there are any art therapists needing work who could take on the group in the community? The chapter I wrote about the group will be published soon.

I thought the acute wards were settling down, but now we have been told that [name deleted] ward will move over to the [name deleted] site. There are also rumours that [name deleted] ward will move to [name deleted] hospital site. That means Mary will have to go to [name deleted] and I will have to travel over to [name deleted] in the opposite direction each week, and we will have to re-think how our trainees are deployed to meet the new demands that will be placed on us.

Mary and I have tried to do an order of art materials but it is proving very complicated doing it across two IPUs in our new job configurations. It was all so much simpler before the restructure. I hope we don't completely run out of paper before they iron out the problems and get us some more.

I have been able to book a nice cottage for the four of us in Cornwall in September so the children are very happy about that, and we are all looking forward to it. They are going to help me paint the end bedroom next weekend. I have lost a stone in weight on the 5:2 diet so it's working really well.

Journal Entry: 16.06.13

A whole year had been taken up with the major restructure (which had followed three previous reorganisations) and the anxieties that went with it, and the situation in LD services was more stable; change was still ongoing, however, in acute services and Mary and I had to manage substantial changes to our practice. I had to let go of an area of work in which I had developed expertise over several years, and was sad about that loss.

My family was feeling happier and more stable, and so was my physical health. In LD services the chaos of the last year was receding into a time of greater well-being for me and my colleagues, though change would always be part of our NHS experience, and in the other post which had been completely changed the repercussions continued for longer.

3.5 Issues that Emerged from my Reflections

The first part of this section of the chapter addresses the issues discussed in Sections 3.1, 3.2 and 3.3 about my experiences in and after working in the specialist unit.

In the Specialist Unit

In the specialist unit, there was a good working relationship with the support workers most of the time, but they did unconsciously undermine our therapeutic work in various ways. Taking clients out of the building when they should have been in sessions, and not being aware of the impact of noise, interruptions, smells, mess and boundary violations on our therapeutic work were constant examples of the issues we faced. The clients and support staff were equally unaware of boundaries, despite our training sessions.

We became increasingly aware of how uncondusive the setting was for therapy sessions, hence our later decision to push to move out of the unit and set up a separate therapeutic centre. There were benefits of having the clients in the same building in terms of our knowledge of how to relate to them, as we had contact with all the clients and staff outside our sessions, but the building was not of a sufficient size to accommodate all that needed to happen within its walls.

The management issues that existed in the unit were an ongoing source of stress for all the staff in the unit, and created difficult dynamics between the staff groups at times. There were many issues concerning staffing, mostly because the support staff were badly paid, did not receive enough training, and consequently there was a high staff turnover. The literature has shown that this is common in LD services.

My experience of managers was mixed. My LD manager was very supportive at times, but was too busy as director of psychological services in our Trust to take our concerns seriously, resulting in us working for several years in the difficult setting of the unit,

before he decided action needed to be taken. Fortunately, my OA manager was always supportive, and ultimately saved my other post when the Trust was planning to eliminate it. Having two posts in one big department was useful, however, as there were links between the two service areas.

Howard, as an employee of the 'other' Trust while we were in the specialist unit, was caught between two conflicting roles, which meant he often felt he had to violate therapeutic boundaries to fulfil his helping role in the absence of enough staff or management. As such that also undermined our therapeutic work, though not intentionally, and Howard lacked the capacity to think about the issue even though I brought it up. This is an example of something that should have been taken to clinical supervision by him.

Working as a close arts therapies team, with the added input of the speech and language therapist, was a very good experience for all of us, and enabled us to develop skills through experimenting with different approaches. We offered support and encouragement to one another that helped us to cope with the stresses we were subject to in that setting, helping us to survive the situation.

Carl and I utilised more proactive self-care strategies while we were in the unit, in contrast to Howard. I had several other stressful factors at work in my life, co-existing with the stress of working in the unit; Carl had to manage relationship issues, and Howard had to manage ill-health. We all realised we needed to think together and to increase our knowledge, and Carl and I both sought academic outlets for our thinking processes. Carl wrote for publication (and later enrolled for a PhD), and I took on the MRes; later I wrote for publication too. Carl sought help from a therapist and his supervisor appropriately, and I had very supportive friends and a supportive supervisor too, but it wasn't until later that we discovered Howard did not receive supervision during his time in the unit, and we were quite shocked by that discovery. All three of us, however, kept up our creative passions outside the unit.

All the staff were subject to strong unconscious communication from the severe LD clients because of their difficulties with communication, and consequently we felt immersed in strong emotions such as frustration, anger and disempowerment, and experienced frequent emotional highs and lows. The countertransference was extremely

powerful and felt debilitating, and we were always very tired by the work. Fear was driven underground and never talked about because of the need to repress natural aggressive responses to client aggression. Instead the emphasis was on trying to understand what was being communicated, though that was much harder for the support staff who lacked training in such thinking. These strong emotions inevitably impacted how the staff, including the therapists, felt while working in the unit.

It was of significant benefit to me and Carl that we worked less hours in the unit than Howard did, and had work elsewhere to give us variety in our working lives. Carl worked two days in the unit, I worked three days, and Howard worked four days; Howard did work elsewhere on the fifth day. This of course meant that Howard was without the support of me and Carl on one day of his work in the unit, and was exposed to the unconscious communications more than we were. He also considered his input, in the absence of the manager, as of high importance – perhaps even feeling he was indispensable, which the literature suggests is a predisposing factor for burnout (Freudenberger, 1980).

It was also significant that Carl and I had therapy as an integral aspect of our training, but Howard did not. Later, when he was burning out, Howard did not see the need to consult a therapist, and did not use supervision adequately as a form of self-help. Perhaps he had not gained a sense of the importance of these factors during his training, which took place prior to their introduction to arts therapies' training courses.

Another significant factor was that when we left the specialist unit, with high hopes for a new therapeutic unit in which we could work in a conducive setting using our hard-gained expertise, we had a long period of waiting for this to happen during which we had to establish alternative working patterns. In addition, Howard's employment moved over to our Trust and he was inadequately managed by John, who remained too busy to be aware of the impact of these factors on Howard. Further, Carl and I were also busy establishing our alternative practices, and we were no longer able to work collaboratively in that setting. So gradually our close-knit team disintegrated, and so did Howard.

I was worried about Howard long before I became aware that he was burned out, and several colleagues did try to help him, such as the deputy manager who was sorting a

room out for him, but the slow progress did not help. I did raise the issue with John and Mary and others, but by the time John acted on his growing awareness that he could not adequately manage so many employees without help, it was too late for Howard. By the time he promoted us Howard had already reached the point of no return, so we were very frustrated by that.

The gradual nature of Howard's decline was noted in the literature as characteristic of burnout (Schaufeli and Buunk, 1996). Howard had gone from feeling indispensable and well supported in a role he was highly familiar with, although in a stressful environment, to an alien environment where he was just one of many autonomous colleagues working independently, and he struggled to establish a niche. Carl and I were both able to adapt within that setting, and for me it was easier because of the locum work I had done. Carl surprised me by his innovative adaptation in which he successfully applied for a job in CAMHS and then adapted his LD work to fit in with that. Howard was unable to find a suitable space to work in, although it would have materialised eventually as the team did eventually find an appropriate space that needed sound-proofing – and that would have happened if he had been able to hold out long enough. By this point, however, he had run out of energy and motivation, and was beyond the reach even of close friends.

The gradual decline crept up on us all inexorably and Howard gradually sank beneath what seemed to me to be like sinking sand. The appearance was of an employee playing the system, being late and absent, and not informing people of what was happening, but his employee record in the specialist unit was exemplary, so it was very uncharacteristic of the person he had formerly been. Carl and I knew this but his employee record did not seem to have followed him into this setting in a different Trust, and others were unaware of the contrast in his behaviour. This is how I knew he was not well and was not dissembling.

However, Howard did not demonstrate any insight into his own condition, or seek any help, which made the situation impossible to manage compassionately. When I started talking about burnout none of my colleagues understood the implications, despite the fact that we worked in a psychology department, and likewise HR had no processes other than punitive ones with which to handle his case. It greatly saddened me that the

NHS could not look after its own staff better. It also greatly saddened me to see such a close friend leave his post under such dismal circumstances.

Themes that have emerged from this section of the chapter can be summarised as:

- 1) Difficulties faced by the clients with severe LD
- 2) The impact of the work with severe LD clients and challenging behaviour, in terms of thinking, emotions and dynamics, on staff and therapists
- 3) Difficulties with the working environment
- 4) Organisational dynamics
- 5) Collaborative work
- 6) Supportive working relationships
- 7) Personal development
- 8) Self-care for stress
- 9) Burnout
- 10) Adapting to change

Next I consider the experiences I had when I went through widespread organisational restructuring in my Trust.

The Impact of Restructuring

This section of the chapter addresses the impact of restructuring processes within my NHS Trust in 2012, several years after Howard burnt out, discussed in Section 3.4.

Change was planned within my Trust long before it was implemented with reviews and audits taking place over long periods, which produced uncertainty in the staff about what it would mean. Although my LD job was safe, my other job was put forward for deletion, although the unions were preparing to argue that it was unconstitutional since we had permanent contracts. For four months, we experienced acute job insecurity, were very unsure what would happen and fearful for the future. We were also very unimpressed with the way we were treated, as higher management never discussed the decision they took with us, or acknowledged that we were human beings rather than numbers. We had no voice to make our views known, and the end of the dementia service came without the Trust having any awareness of it, so the patients also had no voice.

We were moved over to a different service which changed our working conditions substantially, introducing 'agile working': more driving over greater distances, carrying art materials between sites, and identifying suitable spaces to work in. The buildings we were working in were subject to change at short notice, impacting all staff involved, the patients and their families, and our trainees. We were also unable to do any transition work for patients leaving hospital and moving back into the community, which we were unhappy about and thought was short-sighted. There was consequently much adaptation that we had to think through and accommodate, as our entire work structure changed.

Fortunately, LD services fared much better and although they were subject to another move of base the arrangements did relocate health services with social services, leading to much better integration between the two. Hot-desking was introduced as part of the Trust-wide 'agile working' process but was not too onerous as we were organised in hubs. The auditing of our use of clinical space was the most stressful aspect of the restructuring change, as we would not be offered any alternative to the space that had been allocated to us in a previous restructure. Unfortunately, when John retired the memory of what had been agreed by whom went with him, and we were left with less evidence to argue the case.

Interestingly, we were then in another (sixth) base with another move on the horizon (the seventh for our team). I am sure other services have similar experiences and wonder whether the Trust seriously believes it saves money moving its services around different buildings so often. I doubt that it does.

Amid the changes there was evidence of supportive teams that we were part of, and supportive managers. These factors were very helpful in keeping us hopeful even when it seemed unlikely we would keep our 'other' posts. This aspect of the NHS organisation worked well for us.

The scale of change was unprecedented though we had experienced three previous organisational restructuring processes in the Trust. The change impacted the entire Trust, which had grown through taking over a small Trust in a neighbouring area, and radically changed the working conditions of at least half its employees. No staff that I personally knew were down-banded or re-interviewed for their posts, but nurses in acute

services were, and middle managers had to reapply for their jobs. Some years later the management structure of psychological services was also changed and higher managers targeted for down-banding. Mary and I both experienced significant stress related to one of our two posts, and in contrast less stressful experiences in our LD posts.

Our family responsibilities and normal household expenses meant that Mary and I were both dependent on having the income from two posts. We were very stressed about potentially losing a source of income, and there being little likelihood of any other art therapy work in our area that we could take up. We both had a look at potential art therapy work, and found the only likely source was private practice; this was not viable for various reasons, in my case the time needed to complete the PhD.

By this time I had written for publication, had time with my family which I valued, particularly as two of my children were living away from home (and I was by then a single parent), and my physical health was improving. Although I had financial responsibilities as a result of my family ties, I also had valuable relationships with them and with many friends. In addition, I was studying for this PhD, and maintaining my image-making. These were aspects of my self-care that helped me through the anxiety of this period of change in my working life.

Themes that emerged from this section of the chapter were:

- 1) Widespread organisational restructuring and geographical growth
- 2) Job insecurity, uncertainty and anxiety; also job retention
- 3) Widespread change in working conditions in one post, introduction of agile working to both, good integration of health and social care LD teams
- 4) Family responsibilities and lack of employment opportunities elsewhere
- 5) Lack of voice and dehumanising attitude of the Trust
- 6) Adapting to change and increased driving and manual handling
- 7) Self-care

The themes from these two sections of my chapter will be considered in the Findings Chapter alongside the themes that emerged for the participants.

3.6 Chapter Conclusion

The personal knowledge I have gained from the self-search process and analysing my own data led me to understand my own resilience, which has been greatly enhanced by my experience as a therapist and of being a client in therapy. Insight and self-awareness are key aspects of the therapist's skillset enabling me to look after myself adequately. A capacity to adapt to almost constant change, to manage physical illness proactively, and to continually learn and develop my practice all seem to have been important in my journey explored in this chapter. The importance of maintaining my creative process throughout my working life, particularly to explore how I was feeling at given times and to help me think about them, was evident.

Issues I raised in this autobiographical account of my work in the specialist unit for people with severe LD and challenging behaviour showed clearly how difficult the client group was to work with and how important the support of my therapist colleagues, members of the wider team, and my clinical supervisor was. Thinking and communication were major issues, as were the powerful feelings that working with people with severe learning disabilities exposed me to, which left me feeling deskilled, disempowered and useless. Although initially I was almost totally deskilled, as my work developed success was evident in terms of changes to the way clients presented, yet it was hard to discern because of my proximity and the slow process by which it became apparent. My proactive approach to increasing my knowledge, networking and addressing organisational issues all seem to have helped me survive the impact of the work in the unit, as did working there part-time, having variety in my workload, and good supervision.

As I analysed my own data I became aware of splitting that the organisational set-up within the specialist unit created, subject to the management of one Trust with input from a second, and the impact it had on the staff. In particular, Howard had his feet in both camps, as it were, as a member of the therapy team yet employed by the 'other' Trust, hence divided loyalties, evident through his contravention of therapeutic boundaries when the support staff needed additional assistance.

I also became aware of the significant impact of suppressing fear in that setting, and how hypervigilance became second nature, so that when I experienced domestic

violence years later I failed to respond in the way that I would otherwise have felt necessary, exposing me to much unwanted distress in another setting. However, at the time we could not think about these aspects of our experience, consequently I had been unable to raise them in my supervision, and thus was unable to protect myself against their impact.

Howard never seemed to regain his capacity to think about his situation, and seemed unable to access or ask for help that he needed. Colleagues can never force their friends to receive help and I had to process the emotional pain of watching Howard burn out, which took me some years to feel better about, and probably impacted my processing of the material for this PhD.

Looking back, I thought I felt mildly burnt out when I left the specialist unit, though I experienced it more as relief at the change in my circumstances, and emotional pain I needed to recover from (or possibly PTSD), associated with the impact of the work in the unit.

The period of restructuring that I addressed in my last section showed that the nature of the stress at work had changed, and in that setting the impact of the clients I worked with was not so great because their level of LD was milder, but the organisation and its change process produced more stress in its workers. The Trust restructure changed the entire organisation, following reviews and audits that had taken place over long periods of time, which exposed the staff groups to uncertainty and anxiety about the future of their employment over the same long time periods. A number of senior staff decided to retire which left a knowledge gap in the organisation.

I experienced job insecurity, significant changes in my second post, and art therapy initially was targeted for liquidation but saved by the intervention of the head of department, acting as our advocate; agile working was introduced in that setting, and the workload greatly increased. LD services fared better in the restructuring, experiencing another change in venue and pressure on clinical space, although electronic systems had increased the administration workload for clinicians.

These experiences were the catalyst for my decision to investigate the impact of my experience, and that of others who had experienced occupational stress in the context of their work as art therapists with people with learning disabilities in the NHS.



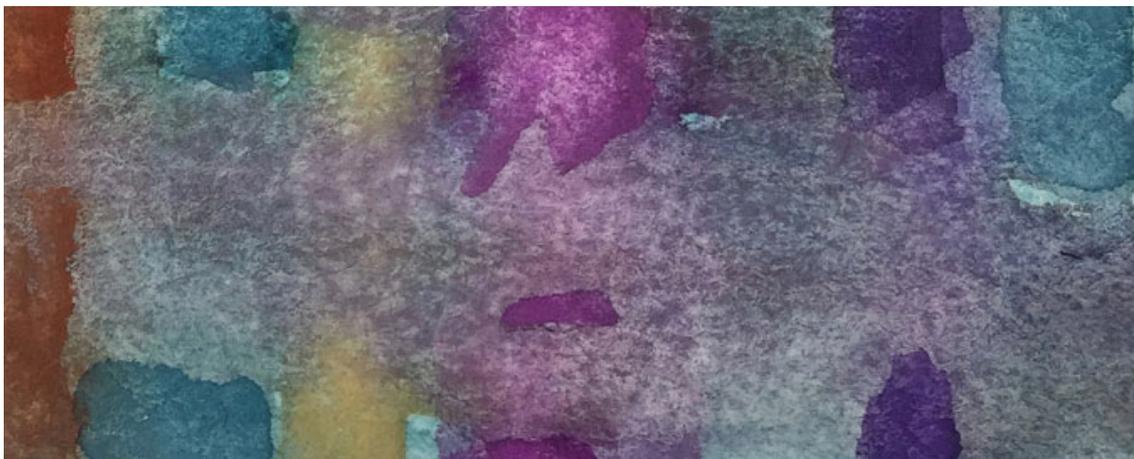
Figure 17: 'Contentment', May 2016

Next

The next chapter explores my findings from interviewing the fifteen participant art therapists, and compares my experiences with theirs.

Chapter Four

The Research Findings



4.0 Introduction

This chapter presents the findings of my research into the impact of the work on art therapists working with people with learning disabilities in the NHS. The chapter addresses three overarching themes that emerged from my analysis of the data from the interview transcripts and my own data, which were:

- 1) Work Intensification, Job Insecurity and Ongoing Change
- 2) Relationships, Empowerment and Wellbeing
- 3) Creativity, Personal Development and Self-Care

The three overarching themes address the issues discussed by the participants as experienced within their NHS Trusts, in their role as art therapists working with people with learning disabilities, and explore how these interacted with their personal lives and impacted their wellbeing. The themes also address these same issues as they affected me, presented in the autobiographical chapter. The themes answer the research questions which were: ‘What is the impact on the art therapist of working with people with learning disabilities in the NHS?’ and ‘How do art therapists avoid burnout in their situations?’

See the Methods Chapter (Chapter One) for an introduction to the fifteen art therapists who participated in this study. The themes are summarised at the end of the chapter.

4.1 Work Intensification, Job Insecurity and Ongoing Change

This theme focuses on the impact of widespread change within my and the participants' NHS organisations during protracted and recurrent restructuring programmes, and the challenges that we faced and had to adjust to. The theme starts by examining what the changes were, then addresses the physical and emotional impact on us; our perceptions and employment situations follow and then adaptations made in response to our situations.

Widespread Change

I and all except one of the participants experienced widespread change as a result of mergers and takeovers, in which larger NHS Trusts took over smaller Trusts. These involved multiple restructuring periods and considerable reorganisation of the Trusts over long periods of time and thus entailed much uncertainty:

‘Since I have been here, which has been about nine years, I have been in about three organisations. So, um, and at times that has been quite stressful, because, er, people have wondered what the arts therapies team should be doing, where we should be, who should be managing us, which directorate or department we should be in and all that kind of stuff. So some of those things have been difficult’ (Andy, 19:26-33).

These expansions increased the geographical reach of the organisations, thereby increasing the population to be served and the area that had to be covered, without increasing the number of staff: ‘...We're just expected to cover a larger area than we did before with the same number of staff, so we're more stretched. That's... more stressful than the actual therapeutic work that I do’ (Walter, 3:26-31).

At the same time cost-cutting was attempted through workforce reductions, by means of attrition, not filling vacant posts, and down-banding; consequently, the work intensified for the staff who were left and had to pick up the excess created. In my Trust, senior staff left as the major restructure was being planned. Two of the art therapists became lone practitioners when colleagues left, one team manager left when their post was down-banded, and other senior staff left for the same reason:

‘And when posts aren't being re - er, you know, if people are leaving they're not being back-filled or, or there's a massive load of re-banding going on at the moment, so all the Agenda for Change stuff is kind of being swept away and people are having their job roles, um, you know, re-analysed and going down a band, and - plus they're doing twice as much work with a lot more pressure’ (Dan, 12:14-22).

The NHS Trusts grew and changed, and along with the growth came increased numbers of patients; but financial austerity resulted in workforce reductions, thus increasing workloads and stretching the capacity of the staff in the organisations. All the participants discussed these issues except Katie; she was about to go on maternity leave, was not currently working with patients because of her advanced stage of pregnancy, and it seemed these issues were not uppermost in her mind at the time. This does not mean that Katie did not experience these issues, just that she was the only participant who did not discuss them.

Job Insecurity

Job insecurity over protracted periods of time caused considerable uncertainty and anxiety, and all the participants (except Katie) and I had been through it, and at the time three participants' services were under threat of widespread cuts:

‘So, as you can imagine, all of this has had a really big impact on me and my colleagues because we've just been thinking ‘well, who's going to go? Who's going to stay? Um - for those people that do stay and for the service that remains - what's that going to be like? How are those few people that are left going to manage to run a service?’ We get a lot of referrals every week, we're a really busy team’ (Ruby 2:13-20).

Emotionally the implications of multiple periods of uncertainty and job insecurity were months of anxiety, coupled with concern about financial responsibilities and whether I and participants could still work as art therapists. We felt somewhat persecuted and undermined, and rumours made us feel insecure: ‘Periodically I go through periods of thinking that I'm going to be made redundant. And I find that really, um, anxiety-provoking...*most* unpleasant and undermining of what one's - all the effort, really’ (Lucy 36:27-37:2).

Planning was impossible during times of uncertainty and resulted in frustration, as staff did not know how long the uncertainty would continue or what the outcome would be:

‘And I wonder how long other services would expect clinicians to manage the level of stuckness that we're at - it feels very, very stuck at the moment - we can't plan anything, um, because we don't know whether we will still be sitting in the same team or not’ (Joan 13:33-143).

Two of the three lead art therapists were suffering from sleepless nights at the time, worrying about changes in their organisation:

‘If I'm having to work late because one of the Heads and I are having to do some thinking - we do a lot over Skype, and I know that it's going to get - it's going to

have an impact and get into me, or it's going to raise my anxiety, then I do take a sleeping tablet to make sure I'm not - otherwise I would be awake thinking about it the whole time' (Rae 42:15-20).

However, all the art therapists whose Trusts had been through recent restructuring did keep their jobs, as I did, for which we were thankful and relieved:

'I was lucky - art therapy was lucky in that service because there's so few of us anyway. They decided they weren't going to reduce the numbers of arts therapists, so we didn't have to be re-interviewed for our posts, which a lot of people did' (Walter 3:14-19).

Again, only Katie had not discussed job insecurity and the attendant anxiety it produces.

Work Intensification

Workloads increased and intensified for the community-based art therapists and me, as did the pace of work: 'I have seen the number of my active clients go up and I've felt... this pressure to speed up and I took on more clients because I felt some pressure coming down that I wasn't picking up' (Simon 3:30-34). The art therapists also identified a culture of 'more for less' that had been developing in their Trusts as they focused on cost-cutting: 'There's always the push to do more, more, more, more...' (Maria 1:27).

As use of technology increased so did pressures in terms of administration tasks, and some participants felt overwhelmed by the number of tasks they had to address and the pace at which they came in: 'I think the problem is maybe having too many things to do and not enough time to do it... I've got to a point where I kind of am ready to declare bankruptcy in certain areas of my job... No, just like - I can't keep up with this' (Walter 20:21-30).

The pressure grew as waiting lists increased, while waiting times decreased, and inadequate management exacerbated the situation for three participants:

'It can be difficult, because everyone is stretched and so it's hard to sit at a meeting and not put your hand up and say 'look, can anyone go out and do this eligibility assessment, we're desperate...' the box is full, but more keeps coming. The pressure grows, the waiting time [keeps being lowered]' (Simon 2:27-36).

For Jill and Rae, two of the head art therapists, there was an increase in pressure which resulted in much overtime due to ongoing changes in the organisation: '...it generates a lot of extra work, which I've been doing on my annual leave, every weekend I'm probably working between four and six hours responding to things' (Rae 41:14-17).

Teams were perceived by seven participants as more spread out, fragmented, and with less contact, increasing isolation:

‘I have one colleague who does work down at the unit with me, a couple of days a week... a music therapy colleague, which is great, and you know, we kind of get on quite well... But again, in reality we actually quite often don't see each other very much at all because we've got back-to-back appointments or just different timetables, yeah. So yes, I suppose I feel more isolated, really, now’ (Sarah 16:4-11).

These pressures particularly affected the community-based participants, whose workloads had increased and the pressure had intensified, however the increase in administration tasks was felt by inpatient services too. As both a community-based art therapist and one who worked in inpatient services I was also subject to these pressures.

Changes in Working Conditions

Reduction of estate holdings resulted in relocations, loss of art rooms and office space, and moves to ‘hot-desking’ and ‘agile working’ for me and most of the community-based participants, as Trusts tried to create more flexible workforces. This meant an increase in travelling between bases and clinical spaces, and in the complexity of our workloads, impacting how well we function:

‘I'm juggling and I'm in a lot of different places in the week, so I could find myself going to three different places in one day, and then being five different places throughout the week, sometimes six, depending on where I need to go. So just juggling my working week can be quite tricky and also juggling meetings can make life a little bit complicated. So for instance, some days I have to swap half a day round with my other job to be able to be in a meeting. All of that impacts on how well I function as a therapist’ (Walter 1:24-2:4).

Stephen found that distances he had to travel had doubled: ‘I'm doing a lot more travelling, so typically I'm doing 800+ business miles a month, so I used to do 300-400 maybe...More than doubled’ (Stephen 15:13-15). Physically this was tiring: ‘I can be quite agile... but it is quite tiring’ (Jayne 34:2-3).

For Stacey, Stephen, Jill, Walter, Maria and me the physical effort required increased: furniture had to be moved, art materials and client artefacts had to be transported when using shared or out-sourced rooms, and psychologically there was an increase in the problem-solving and multi-tasking that had to be engaged with:

‘I'm carrying all my materials in car...my boot is full of materials and then I've got people's art work in folders...sometimes it's extremely worrying - if people have painted and created very kind of wet images then you're kind of - yeah!

How do I fit that in my car? When you've got a small car, and you're kind of waiting for it to dry, or thinking of ways that you can carry it wet, or ...Yeah, so it's tricky' (Stacey 6:26-7:2).

More time was spent in sedentary activity on computers, at desks and in cars, and working overtime increased. For Stephen, Walter, Jayne and me agile working had benefits, such as being able to do their administration tasks where it suited them best, if they were provided with the necessary equipment:

'Because I've got that electronic, like, I've got a laptop, and I do my notes, I tend to do about an hour's work every evening at home, and I get all of my recording done... that's in addition to my normal hours, but what I do, and I do it quite meaningfully now, I mean I always take back my leave time' (Jayne 43:31-44:5).

Although Jayne used her overtime to improve her wellbeing, Simon who also worked overtime did not take it back and it ate into his personal life, as it did in Rae and Ruby's situations.

Driving, sharing space and juggling responsibilities brought psychological anxieties related to route planning, liaison with colleagues, timings involved and exposure to heavy traffic: 'There's always that kind of worry about estimating how long it's going to take to get somewhere when you're going to see a client, in a space where you have to set up the room prior to them arriving...' (Stacey 2:33-3:2).

Working conditions changed for Walter, Jayne, Jill, Stacey, Simon and me, as office space became hot-desking, which entails a greater number of staff using the same office space and sharing desks and equipment which previously each had to themselves. They and I also had moved bases and had to find space to work in unfamiliar environments amongst unfamiliar staff, particularly those who had become lone practitioners, and face those anxieties: 'Though it's within the same organisation, going to a new base is like starting a new job...[different systems], meeting new people, and it can be really...it's stressful' (Jill 9:32-11:2). However, the impact lessened over time as we got used to it.

Most art therapists working in inpatient services experienced little change in their working conditions, however, and were not subject to agile working or hot-desking. Andy and Dan were happy with their working conditions following restructuring, and felt able to manage the pressures they were subject to. Dan worked part-time and did

not have to hot-desk; Andy had a balanced caseload and variety in his working week, and his team had retained their clinical rooms and offices:

‘We've got our own dedicated desk, and we've got space in our - you know, in our office, you know, and we are aware that not only have we got less pressure, we've got a much more relaxed and nicer environment to work in’ (Dan 44:28-31).

Again, the community-based participants were the ones who bore the brunt of the changes, although for half of them working conditions did not change much, but for the third of participants whose working conditions changed in all these factors the impact increased the physical and psychological effort they had to expend.

Interestingly this was not the case in my Trust, as it was in inpatient services when my post had been moved over, that I experienced most disruption and radical change in my working conditions, although agile working was introduced across both my posts. My work became infinitely more complex and the effort we expended also greatly increased.

Difficulties with Working Environments

In my Autobiographical Chapter, it became apparent as time progressed that the working environment was uncondusive to therapy, due to the overcrowded conditions and clients with little understanding of boundaries. Furthermore, boundaries in the specialist unit were not understood by most of the support staff either, hence they unconsciously undermined our therapeutic processes by disregarding timetables or failing to prevent interruptions to sessions:

‘I’m struggling with the noise in the unit, smells from food in the art room and mess left on the floor. There are too many people in the building and it really doesn’t work well with therapy. I really think that the building is not suitable or big enough for day-care activities and therapeutic sessions in the one space’ (J9:15-18).

Some of the participants also had difficulties with their working environments. In one Trust the therapists had been moved from a good environment to a less suitable one in a more remote place, which was harder for clients to access. The rooms were noisy and prone to interruptions, and difficult sizes to accommodate clients:

‘The room we have down there isn't - yeah - very multi-functional, so it doesn't really have an identity, so you have to kind of create its identity...It's quite a

large room actually...and I think that that has an impact as well, if there's just two of you in a very large space, and I think in art therapy particularly there's kind of an interesting use of space. People tend to come in and kind of sit where the art materials are...you have this kind of huge space around you that's kind of empty and a bit echoey, and - er [pause] That - kind of - it could be used but then how do you?' (Stacey 5:4-5, 12-18).

Acquiring appropriate space for art therapy work was an issue for eight participants, and for me in the specialist and mental health units. Stephen acquired a budget for room hire when his dedicated room was no longer available, and developed a database of suitable rooms. Jill had access to Social Services spaces and some of them worked better than others, but the client's location had a bearing on how soon a referral could be picked up and how much impact working in that setting had on the art therapist. The work became more peripatetic in those settings and the therapists, in addition to driving further, also had to transport the art materials and client artwork:

'The drawback is that I haven't got that material to hand there at the session... clearly paint's going to be a problem... I am currently thinking 'how am I going to do that?' ...you can get away with using watercolour because it will dry out pretty quickly, but the previous week was acrylic and that was still wet, and that was rather tricky! So it's about carrying that when it's wet, which is just... [laughs] And I haven't sussed that one out yet, that is an issue!' (Stephen 12:18-19, 25-33).

In inpatient settings, clinical space was difficult to arrange appropriately for Katie, Walter and Sarah. Walter's experience in the inpatient units improved once Protected Therapeutic Time had been introduced, but the nature of the work also changed due to shorter discharge times being targeted:

'We try to do some group work, and also individual work. The individual work I am finding is less and less at the moment, maybe because - um - the way the wards are functioning now there's a lot more pressure to get people in and out quickly than there was before...to have a quicker turnover of patients, get them back out in to the community as quickly as possible and the role really of those wards has become more assessment-based work than maybe therapeutic work' (Walter 4:23-32).

Thus it was apparent that organisations did not understand what was needed for art therapy in terms of appropriate space, and also did not understand about the need for consistency, disabled access, appropriate materials and other aspects of the working environment:

'We've had changes in rooms, which for me has a huge impact, because I need a room that's a base I can work from. If I've got that I can do quite a lot of stuff...

But if the place is under threat, and it's not suitable, um, it impacts on the work really...I think out of everything... that has an impact on me more than anything else, just the lack of that basic need really.' (Maria 6:25-32)

Organisational dynamics were an issue for me in the specialist unit, where two NHS organisations were involved in its running and the unit did not function well in consequence. Splitting was common, and difficulties retaining managers meant that everyday problems had to be dealt with by staff on lower grades or the therapists. Similarly most Trusts worked on a medical model rather than a psychological model, and therefore did not engage well with psychological thinking, as Jayne articulated. Business models introduced another dynamic in the language of money, which changed the focus of the NHS Trusts to financial constraint and tightening of operational resources and expenditure.

Feeling under Attack

Participants' and my perceptions were that the NHS was under attack and its staff were not happy with the direction of changes the NHS faced, there was: '...a lot of anger around, kind of, just the way the NHS - what is happening in the NHS really, and the political world' (Stacey 13:14-15). They and I felt that the mergers and takeovers that took place were predatory and resulted in bigger Trusts with reduced resources: 'I always think they're a bit like Vikings, they're kind of going round to different Trusts and kind of stripping all the assets' (Dan 42:15-20).

This impacted how values had changed, as the Trusts had become more money and budget focused: 'It's all about budgets and money, but when you are in a kind of caring profession for the money to be the kind of driving force rather than the patients' needs, for me it - you know, it's completely topsy-turvy' (Dan 43:5-8) and '...a corrupt value' (Rae 32:27).

Three participants felt they had a voice within their organisation, but most art therapists and I felt that our voices were not heard within the organisations; when serious concerns about planned change were raised they were 'knocked back' (Dan 37:7), and they felt their opinions did not matter to their Trusts: 'It feels very token that they're asking our opinion, but they don't really - they've already decided what they're going to do' (Jill 12:30-34).

Some participants also perceived that there was prejudice against the LD client group and that NHS staff working in that area were marginalised, a view I shared:

‘I mean a lot of us, you know, with all these proposed cuts, we've been feeling upset for ourselves, but feeling upset for our clients because, you know, they're - they don't have much of a voice and, um - yeah, we feel like we're being sort of in a way marginalised, you know, like them turning around and saying 'oh well, actually you're a very expensive service and, um, we can't be spending all of this money on you and your service and your clients', so, um, it feels very unfair’ (Ruby 24:14-22).



Figure 18: ‘Voice’, July 2014

In contrast, I and all the art therapists were committed to work with the client group, even passionate about it: ‘It's a privilege, isn't it? ... [I'm] really quite passionate about the client group, and as a matter of fact, my colleagues are as well, on the whole. Um, sort of very motivated by the work and improving people's lives’ (Jill 43:24, 1:17-22).

Some art therapists felt their organisations did not understand the importance of thinking about the work and processing it; they were defended against the impact of the clinical material, which also meant they did not allow time for reflection on the work except in supervision:

‘I see organisational kind of like avoidance of hopelessness [laughs]...I think everybody wants to kind of avoid those feelings... but I think that in some ways what I feel is that by avoiding those sorts of feelings that something else that I do fear even more - um - is allowed to kind of be put there in its place, really... quite manic sort of responses to avoiding hopelessness, like all just running around and doing a lot of doing’ (Jayne 18:25-19:10).

The art therapists also felt that the arts were marginalised within their Trusts, and consequently there was some reluctance to take the profession seriously: ‘I think there is a prejudice about arts anyway, there's a kind of reaction against - something kind of tricky about organisational processes and arts processes...’ (Lucy 1:23-25).

While participants remained committed to their roles and services they did perceive the changes in the NHS as resulting from political pressure and not necessarily beneficial as the organisations focused on financial matters rather than patient care. Some participants also viewed the arts and the client group as marginalised although they themselves were committed practitioners, and themselves as marginalised if the organisations did not listen to their opinions; some organisations were defended against the emotions that were aroused by patients in LD services. Thus the art therapists represented a marginalised art form and a marginalised client group, which was bound to have some impact on their professional identity.

The art therapist participants and I had felt under attack during restructuring periods when our jobs were under threat, but had all the posts had been retained; this meant relief at the end of the last period of organisational restructuring in the Trusts. However, Rae, Ruby and Joan were still in that uncertain period and consequently felt very anxious: ‘It's horrible, absolutely horrible. And the other Heads in the Trust - there's five of us in this Trust, um, meet regularly. We've got a meeting tomorrow - which has become 'what threat do we have to battle with this time?’ (Rae 41:10-14).

The participants were highly committed to working as art therapists, ten of them having done so for over fifteen years, usually within the same organisation, as I had, and their wellbeing was very dependent on their job security. Those who were the major

breadwinners for their families could not easily leave their employment for alternative work because of the needs of their dependents:

‘I'm the income-provider for my family, um, so I haven't got the option of taking work that's not on a permanent basis, um, or that's at a lower pay, you know, that wouldn't be, er, a pragmatic thing for me to do. It would have to be pretty desperate to do any - to do that’ (Joan 30:13-28).

Being able to continue working as art therapists was important to us, and the scarcity of art therapy posts meant that job insecurity was particularly hard for us, even if participants were recently qualified, because of the commitment that the training had involved:

‘...[to] be able to live, and pay rent, and - you know, run a car, and... And I think that certainly when I'm talking about being very stressed there was, kind of, times when I was very worried about -you know, kind of - will I have a job? And will it be art therapy?’ (Stacey 22:1-3).

The apparent lack of movement in the employment market had significant implications for the art therapists’ career prospects. Though qualified for three years Stacey found it hard to gain permanent employment, and Dan’s NHS role gained two years after qualifying only allowed 20% of his time for art therapy - if such an approach was taken by other Trusts this would represent a worrying trend for art therapists.

It also seems to me that art therapists employed by the NHS would be likely to attempt to weather extremely stressful employment situations longer than is good for them, because there is no easy alternative as there might be for other NHS professionals, such as doctors, nurses and occupational therapists, whose professions have far greater employment opportunities. This is true for me too.

Moving area to seek employment elsewhere was not possible when art therapists had established support and social networks in an area they had come to feel part of, and outside big cities where art therapy was well established it was even more important to retain art therapy posts in their Trusts. Some participants had engaged in strategic planning about where they were living in relation to travelling distance to family, and around children’s schooling:

‘...that took up sort of two or three years before a post came up in [area], and I applied... It worked out well, I mean obviously my parents are kind of getting elderly now, so - I could be closer, but it's close enough to kind of go back and visit quite regularly’ (Sarah 10:15-16, 27-30).

Redundancy might be the only option for some art therapists, however, Rae had been made redundant, had found that experience immensely distressing, and some years later was still feeling the impact. None of the participants were down-banded but Simon's team became very depleted when, following down-banding by their Trust, the team manager and other experienced clinicians resigned, so that only the less experienced staff were left to take on the complexity of the work. Joan and Stephen both became lone practitioners when their colleagues left and their posts were lost or remained vacant, situations that had been replicated over the years in six other participants' NHS Trusts and mine.

Lack of understanding of art therapy was evident in most of our Trusts, thus requiring constant topping up of managers' information on the subject, a process that several art therapists found wearing. The necessity to retain awareness of art therapy within organisations particularly when management changed often was evident:

'I do find that extremely frustrating because I think that, you know, it doesn't matter how many things you - you know, you can present case studies, write papers or engage in research - the research we did here - but it's still asked by your managers' (Lucy 1:8-2:13).

Four of the art therapists worked full-time in one job but Jayne and Simon had considered dropping a day to facilitate their personal art practice. Of the five who worked in multiple roles, most of them full-time, only one participant, Katie, found this suited her, whereas the others experienced significant stress as a result, as I had:

'So in terms of the amount of work I do feel like I'm trying to fit a lot into a week. If it was one job rather than two jobs I think it would be easier to manage, because I would be able to say 'well, I've got four days to do clinical work and then I'm going to give myself a day to have the breathing space to catch up on all the things I needed to do in between the clinical work', but I can't do that with two part-time jobs' (Walter 21:4-10).

Sarah and Jill who had been employed in their Trusts for a long time had the opportunity to move roles within the same service, to improve their work-life balance. I took such an opportunity later:

'I think myself very fortunate really, em, I think it's taken such a long time for the job to- job continually evolving to get to this point and it really suits me being able to, you know, be there for my kids and take them to school, pick them up, that kind of thing, most of the time, and walk my dog [laughs]'
(Sarah 8:27-30).

Adapting to Change

I and the art therapists adapted to the changes in various ways. Some of those for whom driving had increased considerably went to the extent of moving job, team or house, or took on lease cars, to improve their work-life balance:

‘I actually volunteered to move...I used to work in the team furthest away, and it was my choice to move up here and I don't regret moving up here. But, um - yeah, it makes such a difference, you know, if you are travelling an hour to work or an hour and a bit to work...’ (Jill 9:27-31).

Stephen, had to reinvent his entire role to facilitate working as a lone practitioner within a greatly expanded Trust, and although he enjoyed the challenge he had also found it demanding and stressful:

‘...But I think that's the issue, it's ongoing changes and trying to find solutions for things. I think that's what - that is probably difficult enough to do on its own. And what I am kind of feeling is, that because of the other demands on your time... it's squeezing in the time... I feel pulled in two directions, because obviously developing the service in a new way - it's how to do that and find those solutions, but at the same time you are working with all these systems like Rio and all these other auditing things that - well, for the last couple of weeks just before Christmas I was recognising my own stress and my own fears. And I think they've been growing for a while’ (Stephen 12:34-13:21).

Five art therapists, for whom waiting lists were a problem, accessed training in brief therapy approaches, which enabled them to tackle the problem and reduce the pressure:

‘We do now have short-term therapy which is 18 sessions, and that's new to the arts therapists, following training... we decided we needed to do something to try and address waiting times and the fact that some people would be suitable for it, so that's helped’ (Simon 2:44-47).

The requirement to adapt both our function within the organisation according to its demands, and our clinical practice to individual clients’ needs, demanded flexibility and willingness to put ourselves out:

‘I have certain days in the week that are my main clinical times, determined by when the art room's free. And then the rest I can be quite flexible about in terms of meetings for patients and supervision arrangements... so that works quite well really’ (Sarah 8:19-26).

Adapting to change was the alternative to resisting it, which was of no benefit to anyone. We all engaged with change processes, although there was a sense of déjà vu and change fatigue, having experienced multiple restructuring processes. Five of the community-based practitioners were exposed to the most change in their working conditions, thus the greatest number of adaptations necessary and the greatest impact in

consequence. However, I experienced this in both posts, but more noticeably in inpatient services. Successful adaptation resulted in better working conditions for those able to achieve it.

4.2 Relationships, Empowerment and Wellbeing

Three main types of relationships are explored in this theme: those within the organisation, as part of working with clients, and personal relationships. Feelings of empowerment or disempowerment were subject to some of these relationships, particularly with managers and LD patients. Many good experiences and feelings were experienced thanks to supportive relationships and well established therapeutic alliances. These contrasted to the impact of organisational change, and therefore were sources of job satisfaction, pleasure and a sense of the work being hard but rewarding, although unconscious communication and exposure to service users' trauma was often a source of uncomfortable feelings.

Personal relationships were extremely important sources of support, and areas of responsibility which job anxiety was particularly related to. The participants' wellbeing was very much impacted by the factors discussed in the previous theme and how supportive their relationships were, and in this theme we discover how the participants and I fared as a result of exposure to occupational stress.

NHS Staff Relationships and Empowerment

Supportive NHS infrastructures were experienced as the art therapists and I worked as members of teams, or teams within bigger teams, and with managers, clinical supervisors and colleagues. Ten participants received empowering and beneficial support from their managers: 'We've got a really good manager, very understanding, insightful and protective and she kind of acts like an umbrella, so a lot of the things that - that's kind of rained down on us [were deflected]' (Dan 10:2-5). Some teams survived restructuring because managers at higher levels crucially protected their services and acted as advocates for them, as mine had, underlining the importance of such relationships.

Andy, himself a manager, had 'a really supportive boss, who has supported me, you know, beyond the call of duty, I think, at times' (Andy 32:18-20). Andy managed a team of six arts therapists, and after years of experience, some of which had been very

challenging, decided to focus the team on three areas of work – therapy, multi-disciplinary liaison and personal development project work. He approached it in terms of levels of permission to act appropriate to their banding and the goals of the team: ‘I see some of what I do as kind of clearing out obstacles to people getting on and doing therapeutic work, but also making it rewarding and interesting for them. And letting them develop their own practice in a way that is managed’ (Andy 13:1-9).

The participants and I had autonomy and most were empowered in our practice to decide how to approach work with patients, manage our own diaries and boundaries, and manage different organisational demands. We could develop appropriate interventions to address issues the client groups faced, such as creating collaborative groups, many of which were discussed by the art therapists and by me in the Autobiographical Chapter. Autonomy thus increased our personal development, experience, and job satisfaction.

In contrast, three participants felt unsupported by their managers, let down and consequently disempowered, such as Ruby whose manager avoided her when she was experiencing an extremely hard situation that her manager could have helped her with, but failed to. Inadequate or non-existent management resulted in participants having to cope with situations without any back-up, which was also an issue in my specialist unit:

‘We didn't have a team manager or leader, so, um, then for a while we did, but that again was as a time when the whole service was being reviewed and changed... at times it's felt that there's been a lot of freedom, but then when there's times when we've kind of needed back-up and support it's not been there’ (Joan 12:29-33, 11:21-23).

I had mixed experiences of management. Marian had been the advocate we needed and saved my other post when it was threatened, but my experience of my LD manager John was mixed. He had been very supportive of my studying and promoted me, but had largely been absent when we were struggling in the specialist unit and needed his help to address the issues: ‘John hasn't been very helpful in my managerial supervision sessions, I think he's got some stuff going on at home that he's struggling with’ (J9:21-23).

The therapists aimed to empower their patients but to be able to they needed to be empowered themselves; however, sometimes even the managers felt powerless about situations: ‘We had a meeting with the managers about rooms and at first there's

resistance – ‘oh well, we’ll have to go through the protocol’ - and a sense of powerlessness - even from the heads and managers...’ (Maria 16:12-14).

An important source of support and advice was clinical supervision, and we all felt we benefited from our relationships with our supervisors: ‘I’ve always had good clinical supervision, that’s something I can’t fault this organisation around. Um, and I do know that there are places I can take my worries and my concerns, you know, and I can take my fears and anxieties’ (Jayne 6:31-7:2). Unfortunately, Dan’s supervisor had been unavailable for a few weeks due to sickness and work pressures.

I and nine participants worked alongside at least one arts therapist colleague, and seven were members of arts therapies teams, which we enjoyed. Most of us were either managed within psychology teams or in arts therapies teams, having moved away from management within occupational therapy; all were also members of large multidisciplinary teams. Six participants were lone practitioners (that is, the only arts therapist in their area), two owing to the recent loss of colleagues’ posts. They felt isolated in consequence, though four who had been lone practitioners for some time had found ways of creating networks among colleagues in their Trust and in art therapy forums, thus combatting their sense of isolation.

Experience of colleagues within teams was generally very good, and we felt supported by them:

‘I think there’s quite a good general atmosphere, a quite supportive atmosphere really. Perhaps, paradoxically, more so in this new unit, I think we’re all more together because we’re sharing physical space, more aware of what each other are doing, so that feels more supportive and more a part of something’ (Sarah 2:22-27).

When we felt well supported by our teams, managers, colleagues and supervisors that helped us to feel able to manage the difficulties we faced at times in the workplace:

‘I find that the that the team that I am working in, um, are more aware of supporting each other through those kind of issues and processes than any other team I’ve worked with... I think that without a very good team to work with it would be very difficult to do the work...’ (Maria 2:31-32-4:3-4).

In one team that felt very stressed and pressured, however, colleagues seemed preoccupied by their own worries, and possibly were experiencing compassion fatigue, so felt less available to talk through events of the day or de-brief after sessions:

‘Times that can be most strained are when more people at work are feeling the strain too. So actually I'm looking around and wondering where to go. You have leads who are so under pressure that you can't speak to them, and other colleagues sound as though they're really struggling, so you just - well you don't have to, but you, kind of, just keep it in’ (Simon 14:8-13).

Staff teams were also affected by unconscious projections from the patients, which could lead to them acting out: ‘They are difficult dynamics, I think, and also there is - a direct projection from the patients to them - to the staff, and the behaviours get - um, you see the staff behaving in exactly the same sort of risky manner as the patients’ (Katie 29:30-34).

At times, stress due to job insecurity made some teams and departments uncomfortable to work with due to the way they reacted:

‘I sometimes feel it's a bit like a civil war, you know, people start to get at each other, when we're under pressure neighbours turn against each other, and that feels really upsetting... and I feel that's to do with the pressure about survival or something’ (Lucy 38:11-21).

On the other hand, forensic nursing teams worked together amazingly well and kept their therapist colleagues in inpatient settings safe: ‘I sometimes, if there is an incident and I see them all responding, it's just like 'Oh my God!' They are like they are on a mission, you know, they really work as a team’ (Katie 27:12-15).

Collaborative work with colleagues was satisfying and supportive for the participants as it was for me, particularly in the specialist unit, and much of the effective work I did could not have been achieved working alone in that setting. Many of the participants engaged in collaborative work, running groups of many different kinds together, and enjoyed that aspect of their work very much.

Some art therapists worked systemically with the clients’ systems to prevent them breaking down, an aspect of the work they enjoyed, partly because it was so beneficial and partly because it facilitated good collaborative work with colleagues:

‘I think now that's one of the most enjoyable parts of the job, is the camaraderie and the joint working. And I feel, you know, we - that's one of the ways we

handle it, is to hold people together, and I think it can be very rewarding - that - you can build some really great sort of collegial bonds that way' (Lucy 6:3-15).

Those participants who worked in teams that did not engage in work with clients' families and carers found that hampered their work and was frustrating:

'There's a chap that I'm working with at the moment whose mother really...well, I think the mother is clearly in need of therapy herself and perhaps won't really admit that. And it's become her really pushing in and I'm trying to keep her out, but again you can feel quite torn' (Simon 6:39-44).

Client-Related Relationships and Empowerment

Relationships with people with learning disabilities were generally hard to establish, due to the wide range of issues that needed to be addressed, and the range of capacity and incapacity of clients: 'I think that in learning disabilities in the community you've got a really wide spectrum of presenting issues and referrals. Just thinking about the mental health stuff, versus the behavioural stuff, and all that lies in between really - it's quite a wide spectrum really' (Stephen 19:20-24).

Katie, Jill, Andy, Rae and Ruby had experiences of working with people with severe LD; they experienced how hard establishing relationships with people who struggled to communicate was, and so had similar experiences to mine in the specialist unit. However, usually they would be working one-to-one with their clients, or in small groups with carers, and not exposed to so many very disabled service users at once, as I was in the unit. In forensic units, patients were strictly controlled so that the therapists were rarely exposed to the levels of challenging behaviour that I was.

Many service users came from really horrifying situations that felt painful to work with:

'I have somebody who's working through horrible experiences with her support staff but she's going back to live with people who support her, and you know, kind of, horrible experiences with family and then they go back into these family homes, and you feel very much like a drop in the ocean, and I think that when you're exhausted - um, that can be hard to hold against...So you do feel a bit like a drop in an ocean of horror, really, you know' (Stacey 7:18-33).

The LD disempowered both clients and therapists because thinking and communication were difficult. The level of LD and related issues, such as physical conditions like epilepsy and cerebral palsy, had a bearing on what could be achieved in therapy, and the impact on the therapist. The greater the degree of LD the harder it was to think and communicate for both therapist and service user:

‘At the moment I work with people with quite mild learning disabilities, um and I don't find it the same as when I previously worked with people with more severe learning disabilities and challenging behaviour - I think I have had times where I've felt overwhelmingly tired in sessions, and unable to think, with some people, um, yeah, and also feeling very confused about what's going on’ (Andy 3:28-34).

This was certainly the case for me working with people with severe LD and challenging behaviour. The very considerable impact of both the severe LD and the challenging behaviour on me when I was working in the specialist unit, particularly in terms of how to communicate with the clients, was very apparent from my journal entries:

‘...I have to get to know each individual, as they all have different ways of behaving and communicating. Some, like Susie and Mark, can speak and understand speech quite well but their speech is difficult to understand, and Susie has a very alarming habit of waving her hands in your face like she's going to hit you...’ (J1:20-24).

Some participants found the range of issues that had to be addressed kept the work interesting: ‘each piece of work being so different in itself...keeps it interesting. So I don't feel that I ever get bored with clinical work’ (Joan 29:31-30:7). However, for some the slow pace, length of therapy and the tendency for issues to multiply was difficult to manage, as it was for me: ‘People come with one challenge, and then that can just morph and morph into - you know, one thing's supported and then I've got this challenge now, and it can be very hard to find a, kind of, exit’ (Dan 13:10-17).

Increasing complexity and risk in the art therapists' caseloads was the natural consequence of greater caseloads, and many of the clients had had very traumatic life experiences which impacted us as they were drawn and spoken about:

‘...a *highly* abusive background, um, you know, some people in the forensic service have experienced sadistic, er, physical and sexual abuse from a very early age and so I think that connecting with that, with people's pain and their histories and the sort of - in some cases, the horror of what's been done to them’ (Andy 2:27-32).

Engagement was a major difficulty, as it was hard to establish therapeutic relationships with clients and was often therefore disempowering: ‘I have found we have to sort of tailor our approach depending on people's level of ability, and it can be sometimes just about getting engaged’ (Walter 25:8-11). When therapeutic alliances had been established with service users they were sources of job satisfaction and pleasure: ‘In

some cases it has been very rewarding and [a] very, you know, very fulfilling piece of work' (Katie 4:21-23) which the patients also valued.

We enjoyed working with people, and for some the stress inherent in LD work was manageable providing there was adequate supervision: 'I mean I love the clinical work, and it can be stressful at times but that's what we're paid to do, um, and – yeah, I love that part of the work, but it is emotionally draining, and you need good supervision' (Jill 33:22-27).

Several participants spoke about how comfortable they felt working with people with LD, and how they felt they could be helpful to them:

'I started working with people with learning disabilities probably about fifteen, maybe longer, years ago, so there's something about that I've come to feel very comfortable with and kind of, like I'm kind of aware of some of the difficulties people with learning disabilities have and maybe developed a sense of, through that understanding and experience, that I might be of help. So there's a sense of it being... rewarding' (Andy 1:16-23).

Difficulties with thinking and communication because of the learning disabilities people experienced exposed participants to much unconscious communication, and this was also described in my chapter:

'...so much [being] kind of pushed in - in a raw unprocessed state that it is, um, difficult to unravel and to start to unpick it... things are slowed down, or that the thoughts are there but they're just a bit out of reach and hard to kind of - hard to put into words, or hard to kind of formulate a sentence around' (Joan 39:22-40:1).

Some clients were unable to differentiate between thinking and feeling, and the impact of working with such primitive states on the art therapists' thinking was to confuse them too:

'...it sort of stupifies you - is that the word? Or nullifies - yeah, very much so... I can actually feel when somebody has started thinking with me, because your brain is working in a different way - if I've been working with somebody, I can't write their CPA report - it's just like 'I don't know what I'm talking about, what I'm saying! I'd better use some posh words to sound', you know, 'to sound intelligent!' And then, when - the reports where I have a lot to say, I think that's because we are able to think together' (Rae 26:18-33).

However, when able to establish good working alliances with either the client or their carers it empowered both the therapist and the service user:

‘...[the patient] discovered Bridget Riley! And you look at her work and the stuff that she was doing, and his work has gone on to be more geometric patterns and shapes, beautiful, and you can see how he's developing a structure in his mind by - by the structures that he draws. It's beautiful, yeah!’ (Rae 38:31-39:3).

Some service users' frustrations resulted in challenging behaviour, which further impacted the therapists, and much exposure could erode the therapist's self-esteem:

‘...you come away sort of biting your bottom lip at times, with clients that really know how to push buttons - there are a number of our clients that have really tried to - have been bullying, sort of belittling you, making threats to physically hurt you, to being more sort of passive aggressive’ (Simon 11:3-8).

For me in the specialist unit, fear was combined with the nihilistic countertransference brought about by experiencing less stimulation than the severely disabled clients. Fear went underground and became ingrained hypervigilance, hence having a considerable impact both then and later, but was also grounded in not just the threat but experience of physical violence:

‘Some of the clients behave in quite threatening ways, and I have been warned to be careful round Diane because she bites. Tony is always banging on doors and charging about –it's alarming. Jeremy has a nasty habit of grabbing people's hair when you're not looking, and I saw him grabbing Sophie's [support worker] hair and three staff trying to get him to let go’ (J1:26-30).

The countertransference experienced by most participants was powerful, particularly because thinking was so hard for the clients, and clinical supervision was often necessary, and the only place available for us to make sense of what we were experiencing; this made it even more important that organisations recognised these issues and made provision for periods of reflection on the work (which, as noted in the previous theme, not all did): ‘I think there is a lot projected into you. I think there's a lot that doesn't get talked about, or can't be thought about, particularly by the client, that does get pushed into you, and takes a lot of, um, processing’ (Joan 29:6-10).

We experienced many of the feelings that our clients felt, and they often felt hopeless and disempowered:

‘Despondency, feeling useless, worthless, all of those feelings really, um...you know when you - I don't know - maybe a new client who may be quite difficult to engage, isn't turning up for sessions, and then they do and you think 'oh, thank goodness for that!' [laughs] because someone not turning up can make you feel useless’ (Ruby 37:3-15).

In the specialist unit, I and my colleagues experienced the feelings that are commonly felt by therapists and other practitioners working with people with LD:

‘There’s the *feeling of uselessness and being deskilled* that’s so pervasive in the unit – and thinking was so hard for all of us. Perhaps hardest for the support staff because they were not trained to think about meaning in everything in the way the therapy staff do... We all felt so crap, like we couldn’t do anything, change anything – everything took so long...’ (SD 12.3.13:2-5).

We also experienced emotional peaks and troughs during the working day, which were tiring:

‘In one day you can have so many peaks and troughs, you know, coming out feeling really washed out and emotionally tired from, er, you know, quite a heavy abuse thing. Or, you know, going to a safeguarding conference where it’s really, you know, it’s quite heavy. Um, so going into a... session where the parent either isn’t able to... be a positive parent because they’ve not had the experience themselves. Or the parents are fantastic but the child is really unruly. So, you know, you get pulled in so many different directions, so some days I can really come home shattered, um, you know, or flying high and thinking ‘this is great’ (Dan 22:2-18).

Some of the clinical material resonated with the participants’ own experiences, such as Joan’s experience of bereavement: ‘I knew that I had to be OK enough to be able to be with clients who had experienced bereavement and help them with that, and be with their feelings, and not be overwhelmed by my feelings’ (Joan 18:28-31).

As part of their normal working method art therapists have empathic responses to their patients’ experiences:

‘...sometimes a young person kind of gets under your skin a bit more, or you find yourself thinking about them a lot, and it’s not necessarily in a worrying kind of way, I guess, it’s just, you know, a kind of trying to understand, fascinated kind of way’ (Sarah 5:26-30).

The main physical implication of the LD work was that it was tiring, even exhausting, as expressed by all participants; this was partly due to the effort expended unravelling issues that could not be thought about, and in response to the emotional weight of the clients’ material:

‘I think that when I’m physically tired and you meet someone that’s had a really horrible experience, and you kind of start to wonder what you can do, I think, as well, kind of - what am I doing? How am I helping or not helping this person? Yeah, and I think that that is quite draining’ (Stacey 7:18-23).

The tiredness felt was exacerbated by the changes in working conditions, such as increased driving and admin, hot-desking, moving furniture around in shared spaces, and transporting art materials and client artwork; all these aspects added to the sense of tiredness that half the community-based participants and I felt.

Personal Relationships

Personal sources of support were more important than sources at work. I and five participants were single, two because of divorce and had children, while the rest of the art therapists were married or had partners, and most of them had children. Children were sources of joy and concern, particularly at times of job insecurity because of their financial dependence: 'If you've got other things going on in your life, like, you know, a divorce, and bringing up a child as a single parent, then you need stability' (Maria 16:22-23).

Partners or close friends were my and the participants' main sources of support: 'I've got a very supportive sort of husband that understands, em, and I've got good friends around' (Katie 43:19-20). Some participants also had parents or in-laws who were very supportive: 'My wife's parents are fantastic, they're - they live five minutes away, and they're really, um, really good to talk to. They're very non-judgemental and very supportive and encouraging' (Dan 24:13-16).

Several participants were very happy at home and were in a positive and encouraged stage of their lives: 'We live in a nice house, we live in a nice area, we have some - you know, we have some nice opportunities - we've got some good friends, life seems quite good, actually' (Jayne 47:19-22). When support at home was good, and the pressures were not too intense, all was well, but when the pressures increased in every area it was hard for the participants to cope with.

Family life was extremely valuable to the participants and they did not want work to interfere with that:

'I value my family time. And I think it's very easy to let that slip with work, so I have to be quite strict with that, and, um, I'm not the sort of person who'll stay late to finish a report - the report can wait, because my family is important. So if I was going to put anything first it would be family' (Walter 40:26-32).

When life at home was feeling stable it gave the participants a secure base from which to operate in their daily routines: 'I'm very busy and very absorbed and involved in what

I'm doing at home with the children. So, although things might be really difficult at work, when I'm at home I'm at home and I'm a Mum and I'm very hands-on.' (Joan 34:4-7)

Three participants had experienced relationship breakdown, as I had, and were struggling with the aftermath of that: 'I found when I was off over Christmas - I mean I was visiting family and that, but my mind was really on this relationship having broken down, and I really didn't want to end it, you know' (Ruby 33:3-6). Nine participants were experiencing difficulties in their personal lives which included bereavement, parent, partner or child illness, miscarriage, financial strain, difficult family members and temporary housing. I had also experienced a number of these stressors.

When difficulties at home upset participants' sense of wellbeing, and were combined with organisational and relational stresses at work, the combination was hard to cope with. This was the case for nine of the fifteen art therapists, as it was for me much of the time while I was working in the specialist unit: '...it's a combination. If you've got a lot going on personally, of course, and the work is hard-going as well, I think that's hard to hold' (Maria 8:22-23).

There were times when not all the therapists felt supported by their friends and family and everything felt strained, and at such times support at work was even more important, and vice versa: 'I mean [pause] things can feel at times, things can feel very tight and sort of tight, like, mean, I think there's a meanness, in - of compassion, I suppose...not having space for compassion...' [I asked who?] 'Well, everybody really!' (Jayne 17:25-34).

Wellbeing

Job satisfaction was discussed by the participants, and was expressed most often as their enjoyment of working as art therapists and wish to continue to do so. This was what most fuelled their anxiety about job insecurity, as without adequate alternative employment opportunities most participants and I feared we would not be able to find work as art therapists elsewhere, and Joan and Ruby tested that supposition out, finding it to be true in their areas.

Secondly, we were committed to working with the client group, felt comfortable in our expertise with people with learning disabilities, and enjoyed the positive aspects of the work when we were able to engage therapeutically with clients, and good work was achieved. Interesting and meaningful artwork increased our enjoyment of our work, as did collaborative work with colleagues and development opportunities.

We demonstrated our commitment by staying for long periods of time in jobs where the organisation was stressful but the work was felt to be rewarding. When our supportive infrastructures were working well, our working conditions, resources and environments supported our practice, and we had variety in our workloads and did not experience conflicting demands in our roles, we enjoyed working as art therapists in NHS learning disability services. For some of our careers we did experience some of these good factors and occasionally all of them, but the themes so far have shown that many of the ideal situations in our employment were compromised or simply not possible because of the prevailing political and financial pressure experienced in NHS Trusts. Consequently, we experienced occupational stress related to the pressures exerted on us.

Participants' Stress Levels

I asked the art therapists to rate their stress levels between one and ten, ten being the worst stress. The stress levels chart below shows how the stress levels were distributed between the participants, with five occupying the lowest half, and the remaining ten in the higher half of the stress levels, with four on six out of ten, and the rest on eight to nine out of ten. Thus two-thirds of the art therapists were significantly or highly stressed at the time, which was a worrying finding.

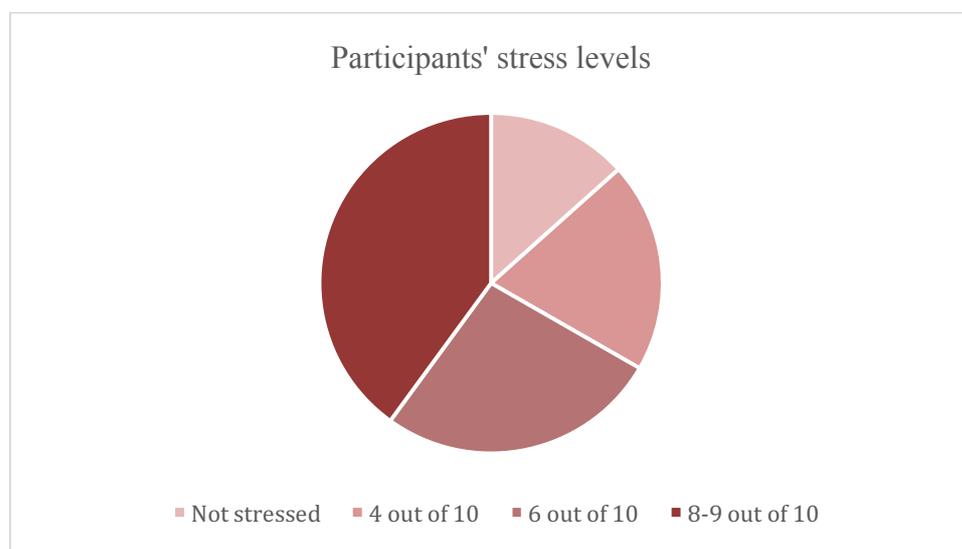


Figure 19: Stress Levels Chart

The Less Stressed Group

Those who said they were not stressed were Andy and Katie, and those who rated themselves at a low level were Stephen, Jayne and Sarah. Andy had emerged relieved from a period of stressful restructuring in his Trust with a budget, the team intact but more spread out, and having kept their resources; he had been well supported by his manager during this process. He had experienced significant difficulties within the team he managed but had reached a comfortable resolution that represented a huge learning curve. If that was not enough he also studied for a PhD, and had experienced considerable pressure during the last months. However, he felt supported at home, had three children, and was feeling peaceful and relieved now it was all over, and not experiencing current stress.

Katie was looking forward to becoming a new mother and about to go on maternity leave, and was not currently seeing clients due to her advanced stage of pregnancy. She had been coping with multiple roles which she seemed to find stimulating rather than stressful, and had fitted a Master's degree and art practice into her busy schedule. She described some irritating aspects of her work, mostly colleague relationships which varied between envious and respectful, and room issues. There were also some issues arising in her second job, but she felt well supported by her supervisor, her husband and a good network of friends, and anticipated needing to reduce her working hours once their child had been born. She was the only participant not to discuss restructuring.

Sarah moved jobs when an opportunity arose to improve her work-life balance, and that proved to be a beneficial change and she now felt she was in the ideal role at this point in her life. She was a supervisor, felt supported by her manager, and had a music therapist colleague who worked in the same building although she did not see her much; she felt the team was fragmented due to restructuring, but that the new service she worked for was well integrated. She had school age children, some financial difficulties and parental illness to manage, but felt supported by her husband, and enjoyed being able to work flexible part-time hours close to home. She had always had a strategic approach to her wellbeing.

I thought Stephen had underestimated his stress level, given he had experienced the most comprehensive change of all the participants, in every area of his practice; however, his management of all this change was impressive. He had made multiple

effective adaptations and now had a supportive manager and team although no art therapist colleagues any more. His art room and base had gone but he had a budget for rooms and good sources; however, he did miss those aspects of his post that he had lost, and appeared to have suppressed those feelings. He faced the reality of a greatly wider patch to work within and took the bold decision to move to a central location, but that had meant living in temporary accommodation with his family for a year with all the limitations that brought, including no access to his art materials. He also experienced intensification of his working conditions because he was now agile working, taking art materials to sourced rooms and finding that difficult; administration had increased, although he had appropriate equipment to help him manage. He was remarkably calm and optimistic, though he was experiencing digestive pain that he attributed to occupational stress, but was hopeful as his family were due to move to their permanent home imminently. He attributed this peaceful state to his spiritual practice, and had self-care strategies he employed, including writing for publication to articulate his thinking.

Jayne felt that her situation worked well for her. She was happy with her home, family and financial situation, and was settled. She felt supported at work and away, and had a good professional network she contributed to and drew on, although in child services she had experienced pressure and stress around some legalistic aspects. Although a lone practitioner she was part of a team, but had three managers who did not understand her training needs. She did not find agile working stressful as she had always worked like that, and hot-desking did not impact her much as she did her administration mostly away from the office. She had a personal trauma history that resulted in depression from time to time, which she managed with therapy not medication, but when depressed she struggled with aspects of the LD countertransference. She did, however, find it tiring, not surprisingly as she worked in multiple locations during her week and drove great distances. Jayne worked paid overtime, allowing her to have time with her children during school breaks, part of her holistic strategy of self-care which also included her art practice and writing for publication.

It is apparent that this group of not or minimally stressed art therapists had employed well-thought strategies to reduce stress, and had achieved personal development goals such as studying, writing for publication, and on-the-job learning curves. Not all were able to employ art practice but most tried to incorporate this into their work-life balance, and all achieved a beneficial level of wellbeing. Crucially, they all felt supported at

work and home. Their Trusts had settled down after restructuring and the outcome had been largely favourable with a few difficulties, except in Stephen's case. Only Sarah worked part-time, but their caseloads were varied and, apart from Katie, they worked in one post.

Stressed but Managing

The next group, which comprised Lucy, Jill, Dan and Joan, all scored six on their stress levels and worked part-time. Lucy and Jill were single, and Dan and Joan both had partners and small children at home. All four worked in NHS Trusts that were going through restructuring and were still experiencing uncertainty despite the process taking a long time already.

Lucy worked three shorter days and combined her NHS work with a psychotherapy practice. She found the Trust restructuring processes stressful, particularly job insecurity and the negative impact that had on the moods and attitudes of other staff. She valued collaborative work with colleagues and seeing the benefits of their interventions to failing placements, but found continual art therapy education for new managers tiresome; however, she was happy to see art therapy gaining more recognition in the media. She enjoyed her art practice, music, nature, relationships with friends and colleagues, was mindful of her need to remain aware of her stress levels, and had strategies for pulling stress back.

Dan worked three days a week for CAMHS LD, with only 20% of his caseload for art therapy; his ten years of LD support work was good experience to build on. His work involved a big learning curve with many skills gained, and he was resourceful, producing appropriate materials for his clients. His team and manager were supportive but greatly depleted, and his supervisor was off sick because of stress; restructuring in his Trust felt predatory and upsetting. He had experienced a sad life event the previous day and was impacted by that. However, at home, he felt supported and had a small son who kept them busy, and he resisted taking on more stressful work to protect his work-life balance.

In Jill's Trust, there had been a move of the community learning disabilities team to social services, and there were difficulties with these arrangements but also benefits. Ongoing restructuring processes meant that Jill was anxious about her lead post, which

was changing. Jill had two arts therapists in her team who were on long-term sick leave and proving hard to manage. Consequently, they were a drain on the team's resources: 'one's definitely burnt out and has been for a long time' (Jill 22:13). Jill felt that the therapists needed to be able to say that they were not coping and seek help, and that if they failed to bad feeling built up, which then added to her stress. Her experience was similar to mine when Howard was burning out, as he did not seem able to seek help appropriately. Like Sarah, Jill had moved jobs to improve her work-life balance; she loved her work, and was highly committed to the client group and the benefits of art therapy. She worked three long days, and had good support and self-care strategies, but parental illness meant she put off studying because of the demands on her time.

Joan had found her Trust's restructuring process sufficiently onerous and chaotic to investigate the possibility of working elsewhere when she returned from maternity leave after the birth of her second child. As the employment situation remained depressed, and she was her family's major breadwinner, she stayed. However, she found the changing managers unsupportive, rooms unsuitable, the waiting list frighteningly long, and her team fragmented. She had experienced a stressful bereavement and her baby was unwell, and she was unable to pursue self-care strategies she would normally employ. However, she accessed brief therapy training and found that enabled her to reduce the waiting list, she had a good supervisor and support at home, and enjoyed being a mother. These aspects helped her cope with the stress at work.

Jill, Dan and Joan all experienced significant personal stress but felt supported. Lucy had a private practice in addition to her NHS work, which meant she had multiple roles to manage, whereas Jill, Dan and Joan only had one job. The restructuring processes of these participants' Trusts were stressful and ongoing, but all the art therapists benefited from working part-time three days a week, as it kept their stress levels down and enabled them to turn their attention elsewhere for part of the week.

The Highly Stressed Art Therapists

This was the biggest group amongst the participants, and I was concerned by the levels of stress they were experiencing in their Trusts, in their work with clients, and at home, although they all had beneficial and supportive aspects to their experience too. The art therapists in this group were Stacey, Ruby, Simon, Walter, Maria and Rae; only Stacey did not raise burnout as an issue of concern. These participants could see that their

capacity to think about their own well-being and take appropriate action was compromised by multiple pressures at work and home, and by the impact of working with LD and raw unconscious processes.

Ruby and the members of her community team had been worried about the future of their service and their jobs for over a year, and were waiting to find out the outcome of their Trust's consultations. She had to work beyond her job description in a role normally allocated to a social worker which contravened her therapeutic boundaries, and her management was not entirely supportive, though her supervision group and colleagues were. She worked three days a week plus overtime during this period, and felt that she had become burnt out; consequently, she worked hard at her holistic self-care, which included therapy, art practice and writing for publication, and despite a relationship breakdown was recovering. She described a difficult experience of the disempowering countertransference, and had thoughts of leaving her job, but loved working as an art therapist. She described how the stress had made her feel:

‘...overwhelmed, panicky, um, tearful, um, just not able to manage - feeling like I couldn't manage, couldn't cope any more. Feeling like I needed to leave, um, dreading going in, um, yeah - constantly on my mind... I just found this was too overwhelming for me really’ (Ruby 26:3-16).

Maria was struggling with the uncertainty and insecurity caused by her Trust's ongoing and protracted restructuring processes, and had a second post that was more stressful than her LD post. She enjoyed working with her team and working collaboratively, had good supervision but a variable experience of management, and found working part-time over four days beneficial to her wellbeing. However, she was a single parent, and was emerging from a difficult divorce and chronic illness. Maria employed a range of creative and relational self-care strategies, and although she felt she had become burnt out, she was recovering and was more aware of the potential impact of stress on her health: ‘When you become seriously ill your priorities change. I think that's the closest to death I've probably ever been to and it makes you re-evaluate your whole life’ (Maria 17:23-25).

Ruby and Maria probably had experienced the emotional exhaustion dimension of burnout, but not the full syndrome, and had developed holistic strategies for self-care that proved effective for recovery. This was an encouraging finding.

Rae was feeling burnt out and was struggling with job insecurity, which was tapping into traumatic memories of being made redundant a few years earlier; she was trying to cope with full-time work, overtime and multiple roles. Rae sounded as though she, too, experienced emotional exhaustion, and that when her thinking was impeded by the powerful LD countertransference she slipped for a period into the third burnout dimension affecting her self-awareness and efficacy. During one of these difficult periods she had become seriously ill:

‘It took me to a very dark place not long ago, um - where I was - you know, with the loss, the feelings of loss as well... I've contracted a kidney disorder...I ignored it, literally did... ignoring even the physical signs - And it's one of those things - if you do go down and you become exhausted it will make you feel even worse’ (Rae 21:11-22:22).

Since this, Rae was more aware of her need for self-care; however, though she lacked a coherent strategy she did have some useful components, such as seeing a therapist and writing for publication. Rae’s mother was her main support at home, where she was a single mother to three teenagers. Her manager was supportive and she had a good team, but was very worried about the possible outcome of ongoing restructuring.

Ruby, Maria and Rae were the only three participants who thought they had become burnt out, and it was good to see that recovery was possible, and that the outcome for them was not as serious as it had been for my colleague Howard. All three had consulted a therapist as part of their stress management, and Ruby and Maria had holistic self-care strategies, which Rae lacked.

Stacey, as a recently qualified locum art therapist, was impacted by the Trust’s restructuring processes, such as hot-desking, relocation, room-sharing, increased driving and agile working, and had other work away from the Trust as well. Stacey worked three days in the Trust, and had other work, so worked full-time in multiple roles. She had been anxious since qualifying about gaining adequate art therapy employment and being able to meet her financial commitments. She was impacted by the lack of employment opportunities for the profession, but despite this had been successful in gaining art therapy posts - she was due to take up a new post in another Trust some weeks later. She did feel very stressed, struggled with the LD counter transference and lack of time for reflection, and with work intensification. However, she benefited from good supervision, was married and felt supported at home.

Walter was struggling with working full-time in two jobs, particularly as his second job was more stressful than his LD work. Restructuring had been painful but with a mostly favourable outcome, in that Walter had retained his jobs and was still able to work as an art therapist, which he had also been anxious about. However, his LD team was more fragmented, and his CAMHS team was still chaotic after the change processes; in addition, the CAMHS role was very demanding and admin heavy, as Jayne found, and the stress built up: ‘...there's been times where I've felt like my head is just a jumble of thoughts and I've felt unable to just make sense of it all, or organise myself, because of the stress’ (Walter 44:5-8).

He had been impacted by hot-desking, agile working, room sourcing and increased driving in the community side of his LD work, and on the inpatient side was more positively impacted by improved patient engagement strategies. Some flexibility meant he could avoid hot-desking some of the time and take refuge in a calmer LD environment, but he still found his stress levels were very high. As a father of young children he was unable to utilise some of his normal coping strategies, though he had a supportive partner. He did not have a coherent strategy for managing his stress, which he really needed to develop.

Simon had been significantly impacted by his Trust’s restructuring processes and there was still uncertainty about his service. Relocations and room-sharing were difficult, agile working and hot-desking stressed him because of lack of equipment. He had a supportive team but they lacked the protective support of a team manager and were all stressed; his workload increased and waiting lists resulted in time pressure. Simon had a varied caseload, but had previously suffered from too much exposure to challenging behaviour. His coping strategies included working unpaid overtime to gain calm office time, he had thought about seeing a therapist and reducing his hours, and he engaged in physical exercise. His wife was supportive, but there were personal stresses at home which meant he was not practising his art.

Stacey, Walter and Simon all experienced significant stress during and after restructuring and seemed to be experiencing emotional exhaustion. Walter and Stacey had multiple roles in different jobs, and Simon had multiples roles in one job. Walter’s experience of hot-desking was not as negative as Stacey and Simon’s due to provision of equipment; they all had to engage in room-sharing, and increased driving. All were

married and felt supported, but Walter was limited in his coping by young children and Simon was unable to practice art because of family stress. Stacey was emerging from post-qualification employment stress, and had a new job to look forward to, hence, she had a more obvious release for her stress on the horizon, which Simon and Walter did not. Only Simon had mentioned therapy, but he had not accessed it. Simon and Walter were both aware that with stress levels as high they were at risk of burnout if they did not act to reduce them.

My Experience of Stress

I had multiple roles to manage for most of my art therapy career, and experienced multiple periods of restructuring within my Trust, nearly losing one of my posts during the 2012 reorganisation. I had variable experiences of supportive management, but always had good supervision, supportive teams, and arts therapist colleagues. The numbers of art(s) therapist posts dwindled from nine to only two as posts were left and lost as attrition; Stephen had experienced this too, but other Trusts retained their art(s) therapist posts.

I experienced significant occupational stress and emerged from the specialist unit feeling emotionally exhausted. I experienced relationship breakdown and my mother suffered from dementia, eventually dying, but I felt supported by my church family, and I had school-age children during the time I worked in the specialist unit. I developed a digestive disorder and had joint issues so had to learn to manage both health concerns, which eventually I learnt to do very successfully. As time went on I became more resilient, and developed more successful self-care strategies, particularly art practice, gardening, study and writing for publication, accessing therapy as a key stress management component when necessary.

4.3 Creativity, Personal Development and Self-Care

This theme is about my, the art therapists' and the clients' creativity, our ongoing learning and personal development, and self-care including stress management. The theme begins by addressing the artistic capacity and its attributes that we bring to our practice, in addition to LD specific and therapeutic skills, then the mixed impact on us of the art produced in sessions by clients is discussed. Job satisfaction resulting from the efficacy of art therapy in practice is considered, in addition to resourcefulness, and mixed success in maintaining our own art practice.

The benefits of engaging in different learning situations were well understood by us, and the second part of this theme addresses personal development and its importance to us and our practice. The learning engaged in was significant in the contribution it made to job satisfaction and personal growth.

Our approach to self-care was bound up in creative expression and personal development, and it seems to be important for art therapists to take care of themselves using methods that maintain their thinking capacities when they are compromised by the work. Stress management became necessary when our self-care approaches were not sufficient to withstand the stresses we were experiencing. The last part of the theme addresses these issues.

Creativity

Our creative drive underlay our functioning, wellbeing, capacity for resourcefulness, and our flexibility and perseverance. Other qualities we had as artists were tenacity, willingness to experiment and adapt our approach, to think and reflect deeply, and to work intuitively with or without a pre-planned strategy. Thus we were equipped to work with flexible person-centred approaches with our clients, to adapt to different demands of our organisations, and these capacities contributed to our resilience.

Meaningful and interesting images made in sessions were sources of real satisfaction and appreciation:

‘Some really nurturing things... happen, for me, in the art-making... when I think back about to, um, some of the art-making that I've seen, I feel very privileged to have seen what I've seen, because I feel like some young people have come and they've - at times they've made very important work. Um – and... they've made artwork that's really - inspired me, in a way, like, they've made artwork that I've seen, like, in galleries, you know, by people who've spend a career trying to get rid of their art school education, you know, like, they've made - they've made art-making that's been really very much a response from...their inner being’ (Jayne 24:2-17).

However, patients’ creativity could also be destructive, and even distressing:

‘...some of that destructiveness, you know, has been startling, kind of like, expressions of a quality of anger, self-persecution really, that I've found very difficult to witness at times. I've always been thankful that it's happening with the materials, you know, and it's been... made in an artwork - but it's still very difficult to... I think it's difficult to witness - because nobody wants somebody that young to be experiencing those sorts of things’ (Jayne 25:32-26:10).

The quality of the artwork produced by service users varied considerably, as did the impact on us, for whom it could really impede thinking:

‘My colleague and I here, we run the art therapy group together and we both will make art, you know... And that creative flow is just like sludge... There's something *so* blocked and - I don't know how to explain it - I mean there was one man I was working with who... drew a house with four windows in a square, no roof, and he was looking at it for ages saying there's something missing - and I couldn't even think what was missing! It was the front door - you know, that's the effect it has’ (Rae 27:4-26).

Similarly, the artwork produced by the clients in the specialist unit was of an early stage of development and lacked sophistication:

‘The lack of aesthetic stimulation, because their artwork is at a pre-representational scribble level, is a bit of an issue for me, although I enjoy the colour combinations Liam uses. I am able to give him choice in the sessions, in contrast to most of the rest of his day, and I discovered that he understands the names of the colours so he can pick what colours to paint with by pointing at them. The paintings are lovely wet, but lose their luminosity when dry. He always paints in arcs, covering all of the paper, and never wants to do anything different.’ (J5:11-18).

Clients’ artwork could deflect some of the impact of unconscious patient projections on therapists that otherwise might be acted out, thus protecting us from what would otherwise be challenging behaviour:

‘Some people - first of all, some people may not talk about this and people may just draw about it, so I think that is where the art comes, you know, the containment of the projection and the introjection of stuff comes, em, comes ahead and, you know, with some of them it's a very direct way, therapist is getting abused, you know, it's not them, so I'm in a house where people are coming to beat me up, or you know. So they are using me as an object as well as a vehicle of communication’ (Katie 49:19-27).

The sensory nature of art materials was helpful for many LD clients and some materials were particularly helpful, such as paint, sand and clay. Sometimes though they had unexpected results, such as when autistic clients tried to eat them, which was challenging:

‘There were occasions where he tried to eat the art materials as well, which is quite stressful, because obviously there's dangers around that. And there was one occasion where he actually grabbed a pot of glitter and poured it down his throat and I was like trying to reach out and stop him, but he moved so fast it was really hard to get there in time! Um - I found myself with him trying to bring in materials that I knew were edible!’ (Walter 24:9-24).

The efficacy of using art within art therapy with clients was a source of job satisfaction in terms of how it enabled work with many varying levels of ability, as I found in the specialist unit: ‘I think I work with the creative medium to help the incapacity, if that makes sense, I think that I'm expecting that as an art therapist you will be able to engage to some level even if there's not that much of capacity or ability, I suppose’ (Katie 45:25-29).

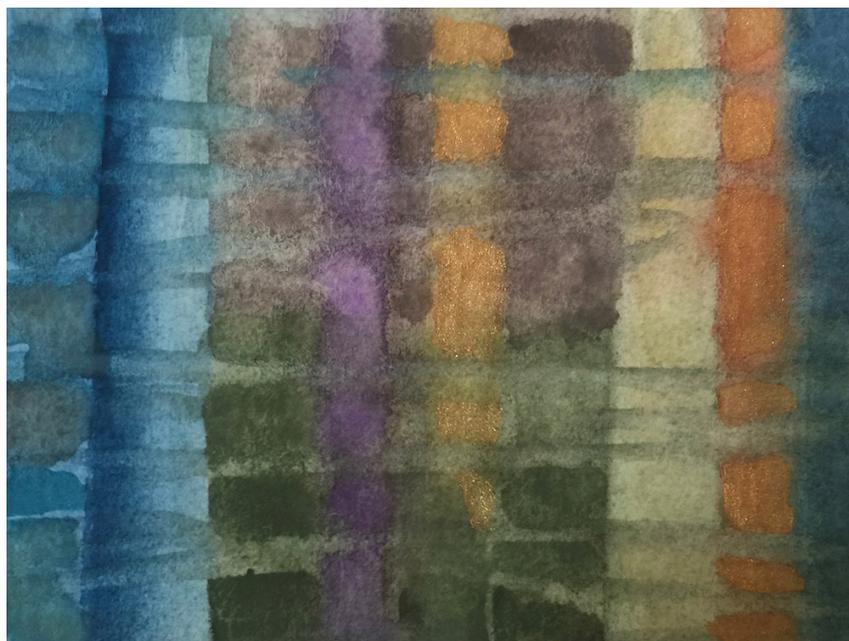


Figure 20: ‘Bronze Blue 2’, June 2016.

Being able to change the clients’ carers’ perceptions and increasing their understanding of what clients were communicating through the art was also satisfying:

‘Art's a fantastic medium, you can actually show different sides of the client to the staff, which is good, and let them into their inner worlds and how they see things... even in a very short time we can make quite big changes to how staff perceive their clients’ (Jill 2:34-3:5).

Where art facilitated communication, particularly when thinking about issues was difficult, this was extremely beneficial to the work with people with LD and was therefore a satisfying aspect of the work:

‘The artwork I think helps some people to put on paper something that they can then talk about, so I think it can be a communication tool - sometimes when people think of a picture, they draw it or paint it or whatever, and then that can be the subject of conversation. So I've heard people say that drawing a picture, getting it out of my head helps me to think about it, and it's easier for them to think about things because there's a point of discussion, almost as if sometimes they're trying to illustrate something, can't really put it into words, but once it's

there, there are more possibilities of what it could be or what it means. So I think that can help people' (Andy 4:31-5:10).

Taking clients to art galleries and exhibitions, and witnessing life-changing impact on their clients, was a source of pleasure, satisfaction and encouragement for some of the participants:

'We've set up this thing going for trips to the Tate Modern... I have one guy who, um, I'm still working with, who committed the most *heinous* vile offence, but has actually discovered his own mind - and then discovered Bridget Riley! And you look at her work and the stuff that she was doing, and his work has gone on to be more geometric patterns and shapes, beautiful, and you can see how he's developing a structure in his mind by - by the structures that he draws' (Rae 38:24-39:3).

Our resourcefulness was beneficial, as it resulted in creative approaches to problems and the capacity to produce resources where necessary: 'I've done a workbook on anger management, I've done one on anxiety, self-esteem...and then either making key rings as reminders or doing them things that they can hold onto and take away with them' (Dan 14:14-15:22).

All the art therapists considered that it was important to maintain our personal art practice. Some participants managed to keep a studio, and many made efforts to keep some image-making going:

'I've had the studio for about five years now and it's just great. And I have kept doing my own art in that time, since having the studio... I really enjoy going down there... feel very lucky to have that really... We have kind of an exhibition space where the studio is, so um, at the moment I've got about six pieces of work up there and we've had various group shows over the time that I've been there.... I'd probably like to have my own exhibition at some point rather than just doing the group shows. I've got a body of work that I'm kind of happy with, so I've probably got enough for my own exhibition now really... And that does sustain me' (Ruby 42:6-43:3).

The demands of small children and other issues made it hard for some participants to maintain their personal art practice: 'I miss being able to use some of the coping strategies that previously I kind of used, but I think that's about having small children...' (Joan 34:34-35:2). This reduced their sense of wellbeing and a source of personal satisfaction, though more time with their children provided a positive counter-balance, along with the knowledge that it was for a season. '...we play with [our son] quite a lot. I mean he's quite a good de-stresser...' (Dan 24:6-7).

I found it both enjoyable and satisfying to produce artwork during the course of my working life, and particularly while working on my PhD, as evidenced by the images included in the thesis. The artwork was produced in different contexts – while working with clients, at home where I created a studio space, and at college – it was always important to me to create an opportunity where possible to make art. I am sure it enabled me to ‘think outside the box’ many times, and I have observed clients being able to think better in the creative space of an art studio, even if not making art, than in the less obviously creative space of a counselling room.

Personal Development

Learning was shown to be highly beneficial for art therapists working with people with LD despite the hard work involved, as I experienced. Three participants had put themselves through advanced training courses or master’s degrees, one had completed a PhD (with much support from work), and one had further trained as a psychotherapist, which taught her:

‘...a great deal of theory about development - developmental states and early states and primitive states of mind - I found that really useful for this client group too - body, about the importance of the body, er, how body sensations need to be thought about in order for anything symbolic to occur, there's loads of really excellent of theory, I think’ (Lucy 18:32-19:4).

Thus our learning contributed to our knowledge and capacity to work with additional skills, increasing employability, and though challenging increased our efficacy as art therapists with our client populations:

‘It was a really intense learning experience, so I learnt a lot of skills - project management skills, collaborative working, data analysis, and reading quite widely around my subject area, which is forensic learning disability, and knowing more about the kind of offender - work with offenders in general’ (Andy 16:33-17:4).

Learning curves were also experienced ‘on the job’, and as participants developed their experience and expertise they learnt specialist skills such as ‘intensive interaction’ (Hewett et al, 2011) – one of the trainings offered to me in the specialist unit. Stephen had to use a wide variety of skills to reinvent his role when he became a lone practitioner, his role changed to cover a much larger area, and his working conditions all changed - it was both a huge challenge and a great learning curve.

Andy faced a considerable learning curve, too, when he took on the role of Head Art Therapist for a team that initially presented him with personality issues and painful

managerial challenges, and needed him to make some major changes in the way it functioned. Dan's role in LD CAMHS exposed him to a role that demanded many skills in addition to his art therapy skills, such as learning 'Theraplay', and equipped him to undertake many complex assessments with children and their parents/carers. I too experienced a steep learning curve in the environment of the specialist unit, and greatly increased my knowledge and experience in the process.

A third of the participants accessed training in brief therapy and added that to their skillsets, enabling them to tackle growing waiting lists. Many became clinical and placement supervisors, stepped up to managerial tasks, and a few became lead or head art therapists, as I did. These achievements increased job satisfaction, and in some cases income, and thereby wellbeing, as well as satisfying altruistic concerns.

Three participants had set up pioneer art therapy services in different areas at different stages of their careers, Rae most recently, therefore some new art therapy posts had been gained. Rae enjoyed the challenge involved in pioneering a new service, and gained much satisfaction from these endeavours: 'I know this territory - I love setting up new services, I love designing new services, I love that challenge, and pioneering' - I'm all about the pioneering' (Rae 2:14-17).

I and seven of the art therapists wrote for publication, contributing papers to the art therapy journal *Inscape*, chapters in edited books or edited a book. Thus we had helped others in the profession by contributing our knowledge and experience, and had articulated it for ourselves too: '...very early object relations, yeah... I've kind of written a draft of a paper about that, I'm trying to link intensive interaction with theory that, you know, underpins art therapy theory, which I think is largely object relations' (Ruby 22:26-32).

Three of the participants were engaged in writing professional guidelines for people with LD, which I also contributed to. Jill, Ruby, Andy and Lucy had engaged with art therapy research, either in an academic context or in their workplace, and Andy and Rae presented at conferences. Continuing to read appropriate literature to inform practice was also important. Most of the participants and I also engaged in networking within the profession, as members of the Art Therapy and LD special interest group, some serving on BAAT council and as SIG co-ordinators.

In addition to contributing to our continuing professional development, which is a requirement of HCPC registration, these learning engagements gave us opportunities to think without the limitation of the LD, interested and satisfied us, and exposed us to challenges that developed our characters, and increased our expertise.

Self-Care and Stress Management

Of the five art therapists concerned about burnout, the three who experienced emotional exhaustion had sought therapy to help them, and become more aware of the need to be pro-active about self-care. Ruby and Maria both worked part-time and had found that very helpful, whereas the others worked full-time, and Walter and Rae worked in multiple roles; Simon, Ruby and Rae also worked quite a lot of unpaid overtime, which would seem to be an indicator of potential stress overload.

Rae knew that her self-care was not adequate for the levels of stress she was experiencing, but had a few strategies involving personal care, seeing a therapist, and being creative when she could. She had an elderly mother who gave her valuable emotional support, and also had a good manager who encouraged her to look after herself. The main improvement Rae could have made, if financially viable, was to free up some of her time to give herself a better work-life balance, it seems to me.

Ruby utilised positive thinking to help herself cope with feelings of disempowerment and hopelessness. Realising how stressed she felt meant that she had sought areas for personal renewal. She developed several projects which involved private art therapy practice, her image-making and maintenance of a studio, and looking after herself by seeing a therapist. She seemed to have experienced a period of personal growth in consequence:

‘Everything else I do is related to the art therapy, so whether it's making my own art, or obviously developing the private work, doing the writing that I'm doing, delivering a bit of training - all these things - they're all related to the job but they're kind of - perhaps a bit more creative. I think it's so important to have that balance... yeah - there is a bit of personal growth going on at the moment, and I think that happens - when there's a bit of a crisis, or a crossroads...’ (Ruby 45:6-19).

Maria worked four days a week and also found that not working full-time helped; she was divorced and a single parent, and was coping with job insecurity and changes in her working conditions in a Trust that was going through restructuring. She had seen a

therapist, engaged in many creative activities, and valued relationships with close friends; recently she had started a new relationship and that had brought her into a much more hopeful frame of mind.

Ruby, Maria and I provided useful data on how to recover from emotional exhaustion, a component of burnout, as I had experienced emotional exhaustion on leaving the specialist unit. Since then, I and several participants had taken steps to protect our mental and physical health. Stephen was a good example of someone who was coping with massive change in his working conditions, had been stressed and felt unwell, but continued to have an outlook that was optimistic and hopeful; he had supportive personal relationships, and a good manager who encouraged his autonomy. He was not afraid to make major changes in his life to improve his work-life balance, and similarly Jill and Sarah had also both made major changes by moving jobs to improve their work-life balance.

Andy had also been through recent high stress during the end of his PhD studies but had good supportive structures in place, and when it was over he felt, in contrast, peaceful. Jayne made sure she had regular holidays, practised mindfulness to manage recurrent depression, nurtured her creativity, attended a monthly dance movement therapy group, and had good supportive relationships at work and home.

Some art therapists intuitively developed coping strategies that worked for them but, bearing in mind that only two participants were feeling stress-free, most needed to be cognisant of their work-life balance and proactive about their wellbeing needs. Stress could build up and once therapists were aware of that they could take remedial action: ‘...it's always, um, a juggling act, that - you know, I think always there's a point of getting over-tired and anxious, and then thinking I need to pull that back’ (Lucy 34:33-35:4).

As thinking and communication was often difficult working with this client group, times for reflection on the work, clinical and peer supervision were valuable tools in the work and usually available. Supervision is particularly important for therapists, as they need to discuss their questions and difficulties in the work, to enable them to think about it with another person. Three participants found that the changes in their working

conditions resulted in a lack of time and access to conducive environments for reflection on their work, and they were amongst the most stressed.

Imbalances in caseloads caused difficulties for some participants, such as Simon who had too many service users with challenging behaviour on his caseload and had to address that. Others felt theirs were well balanced and therefore beneficial for their wellbeing: 'I think I've been quite lucky in the sense that I have mixed a week, I've got a bit of academic stuff, I've got a bit of managerial stuff, some supervision of staff, some work with the multi-disciplinary team and some work with patients' (Andy 8:18-24).

Working part-time was considered extremely beneficial by the seven participants who did, particularly those with small children who found that benefitted their work-life balance, and two others combined their NHS work with private practice and enjoyed the variety that gave them in their work: 'I like working part-time because then you have got other times in the week where, you know, you've got time to kind of develop other things' (Ruby 45:4-5). After twenty years of working in my NHS Trust, having observed the benefits of part-time work for the participants, I chose to reduce my working week by one day, and to leave my second post to simplify the demands on my time. I found these changes greatly benefited me, and helped me find more time to finish the PhD.

Dan, Walter and Joan were not able to employ some strategies they would previously have used because they had small children at home. Walter had a greater struggle to manage his stress because he worked full-time in two jobs, whereas Dan and Joan worked part-time in one.

Being organised about taking lunch breaks would have been helpful but most participants did not factor that into their working day, although Sarah used that time to walk her dog, which she found very beneficial. Some of the parents made sure they took annual leave during school breaks, and others found that children's work slowed down during school breaks giving them some breathing space.

On the next page is a diagram illustrating the stressors identified in this chapter and the protective factors.

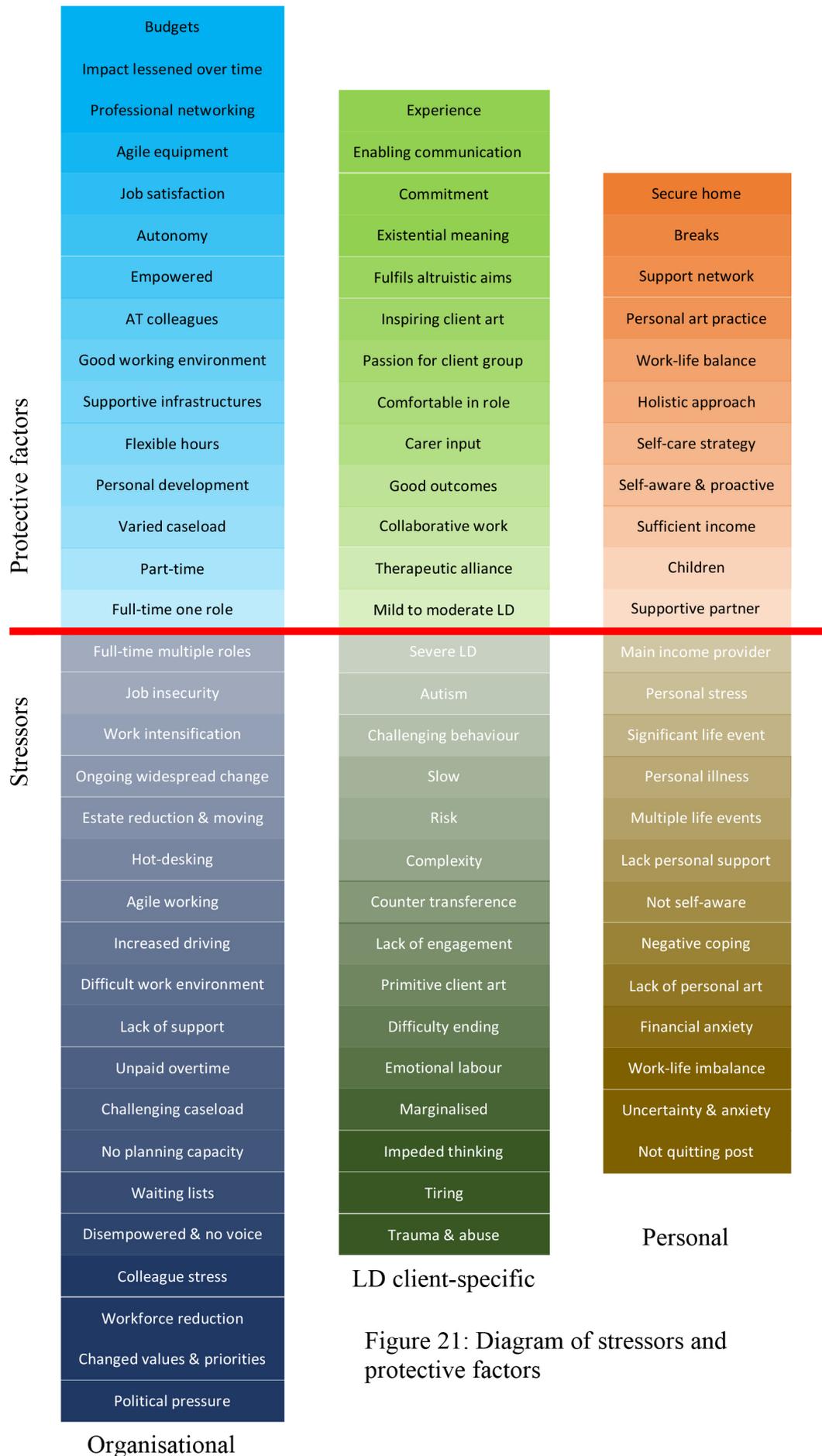


Figure 21: Diagram of stressors and protective factors

We have seen how important relationships were for the participants' wellbeing, both at work and at home, and these were important aspects of the participants' lives for reducing or managing stress, as they were for me: 'It's about good, really good personal relationships really, you know, with friends and - men and women... close honest attachments over time, so family and colleagues - they're absolutely important to me' (Lucy 34:12-17).

We have also seen how maintaining their art practice was important to the participants, but difficult for those who were juggling multiple roles and/or had small children. Two participants had thought about reducing from full-time to four days a week at work to facilitate their creative drive, but had not yet taken that step; others felt guilty if they could not find time to make art. All knew it was important to maintain some creative activity for their wellbeing.

Added to the approaches noted above, most art therapists employed a holistic balance of coping strategies which benefited them, though a few needed to improve theirs to reduce their stress levels. Going to the gym, walking in nature, digging the garden, and other physical activities were beneficial for many. We have seen how academic studies and writing for publication enabled them to engage in thinking at deep levels which they could not do in the context of their work, though two had to put their studies on hold while they coped with difficult personal situations. Psychological interventions were employed when they were felt necessary, such as mindfulness, personal and arts therapies, humour, positive thinking and ensuring they slept well. More general forms of relaxation such as reading, personal care, cooking and watching films with a glass of wine were popular too.

It became apparent to me that a self-care strategy is not the same as stress management. Every employee needs a self-care strategy, and as discussed above, one that is holistic, strategic and individual to each person's needs, and it should be reviewed at regular intervals. Stress management becomes necessary when the self-care strategy is proving insufficient to manage an increased level of stress that we are struggling with and need to reduce, and usually entails some intervention. Ruby, Maria, Rae and I, each of whom experienced emotional exhaustion, engaged in therapy to assist us to recover and that was stress management; it was evident that Ruby, Maria and I also increased our self-care strategies to a level that not only enabled us to recover but brought us enjoyment

and led to personal growth. This approach, and the data above, would seem to provide us with a good pattern for the future in our employment, although interventions for stress management might also involve holidays or times off sick, for instance.

4.4 Chapter Summary

The data showed that ongoing change in NHS organisations was experienced by me and the majority of participants, and resulted in the art therapists continually having to adapt to changing situations. There was widespread change in which the NHS Trusts expanded due to mergers and takeovers, which affected most of our Trusts, and workforces were reduced. Consequently, job insecurity impacted most of us over protracted periods of time, resulting in much anxiety. Ultimately we retained our posts, so were relieved and happy, though a few art therapy posts were lost because of attrition or downbanding. I was the only art therapist whose second post was forcibly moved to a different department.

Most of the community-based art therapists experienced intensification of their workloads because of combined processes of expansion of their Trusts and reduction of the workforce. These resulted in greater workloads, increases in waiting lists with lower waiting times, more administration tasks, and the pace of the work increased. Working conditions changed considerably for a third of the art therapists, who lost their art rooms and office spaces, and one participant's entire working practice had to change. There was, however, little change for the art therapists working with inpatients in established premises and some community-based art therapists retained their clinical and office spaces. In contrast, my inpatient post experienced more change than my community-based LD work.

We viewed our Trusts as having shifted their focus away from patients towards financial austerity, and that their values had changed in the process. We recognised that the NHS was under political pressure, felt the client group was marginalised, and perceived a prejudice towards the arts, which negatively impacted our professional identity. We also considered our teams were stretched and fragmented during recent restructuring, increasing work intensification and reducing supportive contact between

team members. In addition, we felt that consultation was largely token, and that our voices were suppressed by the organisations during restructuring.

Organisational dynamics were very apparent in my situation in the specialist unit, subject as the unit was to splitting between two organisations, which had a considerable impact on the staff working there and the way the unit functioned. Within NHS Trusts there was also evidence of change in organisational dynamics as we became aware of a different attitude developing, reflecting the prominence of financial concerns, increased pressure levied on us, and a dehumanising attitude apparent in lack of voice and concern about patients. At the same time, healthcare continued to be managed within a medical rather than psychological model.

In response to the change in our work situations all adapted our practice where necessary, with some taking their adaptation to extreme lengths such as moving house or job, demonstrating our commitment to our posts and our capacity for flexibility.

The processes that the NHS Trusts engaged in, to achieve their goals of widespread and far-reaching change, were experienced as demanding and stressful. They took place over multiple cyclical periods of uncertainty and change which took their toll on us, and there was evidence of change fatigue among us.

Relationships with colleagues and supervisors were generally good sources of support and collaborative endeavours, and two-thirds of the art therapists had good management that supported their autonomy, appropriate backup when needed, and thereby empowerment. One third of the participants were negatively impacted by management structures that were changed by restructuring in their organisations, and without adequate support they struggled and felt disempowered, as I had at times. All had good clinical supervision, which was relied on to help unravel the complications of the clinical work including unconscious communication and difficulties with thinking, as well as ameliorate the impact of the work.

We were all members of teams, which particularly benefited the established lone practitioners; working alongside another arts therapist was very beneficial for all who were. The two art therapists who had recently become lone practitioners were feeling the loss of their art therapist colleagues. Good and supportive relationships with

colleagues enabled us to talk to peers and feel contained; however, colleague relationships could be compromised by too much pressure from work or during periods of considerable anxiety about job security.

Relationships with people with LD were hard to establish and maintain, but we became more comfortable working with the client group as we gained experience, and many worked for most of our lives with the LD client group. There was less impact on us if we were working with people with mild or moderate LD for whom thinking and communication were less of a challenge. However, people with severe LD were hard to work with for protracted periods of time, and community-based art therapists were exposed to more unconscious communication and challenging behaviour. In forensic inpatient services therapists were more protected from challenging behaviour by the judicial structures they worked within, but unconscious processes were very powerful. The efficacy of the art therapy process and use of the art materials overcame some of those difficulties and were thus empowering, but the work was still very taxing.

As caseloads increased so did the complexity of cases and incidence of risk that had to be managed. More professionals had to be involved and some of the situations were hard to resolve, such as Ruby's experience with a challenging client and the funding process she was forced to engage with. The process had nothing to do with her job description and she had inadequate support from management, hence was disempowered. Fortunately, the other therapists avoided case management.

The emotional weight of the LD work also had a considerable impact, in terms of the countertransference experienced, and very disempowering feelings that the clinical work gave rise to. Hopelessness was a particularly powerful feeling that related to the horror of the situations the clients were exposed to and hearing accounts of those, as well as the service users' vulnerability in society and the complexity of some of their intractable situations. Our thinking was also considerably impacted by working with the difficulties in thinking and communication that the patients exposed us to, which added to our pervasive sense of uselessness and disempowerment. The powerful projection of feelings was harder to rise above when there were multiple organisational stressors to manage too, and worse still if combined with personal issues as well.

Personal relationships, such as those with children, parents, parents-in-law and close friends, were extremely important to us, the main priorities of our lives, and for most were extremely supportive. However, some of the art therapists were struggling with difficult home situations, which put a strain on them, as Chapter Three showed it had with me.

Those who experienced job satisfaction, support at work, stable home life and enjoyment of the clinical work found that contributed to wellbeing and to our desire to stay in our jobs.

When stresses combined from multiple sources within the organisation, the client work, and at home, these conditions resulted in the greatest levels of stress, and of physical and mental ill-health. LD work was tiring, and for the five community-based art therapists who experienced most change in their working conditions these added to the tiredness they felt, which I also experienced. The stress levels of some of the participants had reached worrying levels and needed addressing as a priority.

However, resilience was evident in me and most of the participants, who bounced back from difficult circumstances and adapted to constant demands and changing situations. Even those therapists who experienced emotional exhaustion recovered and thereafter were more self-aware and proactive about their needs, developing resilience.

Art processes greatly assisted the difficulties with thinking and communication that I and the participants experienced, and resulted in meaningful and healing image-making in many cases. I and some of the art therapists found the severity of thinking and communication difficulties resulted in a negative impact on both the therapists' and the clients' artwork. Resourcefulness was a useful capacity, increasing our ability to be flexible and adaptable. The art therapists' own art processes were important for maintaining their creative drive and as coping mechanisms, but were impacted by being too busy, strained or because of the demands of child-care.

Their ongoing personal development was equally important to their experience of the workplace, and represented very hard work and considerable commitment, as much of the learning took place in their own time. What they learnt contributed to greater job satisfaction and wellbeing, as well as increased knowledge (their own, and contributed

to the profession), expertise and thereby their employability. It was also useful as a coping strategy to combat the attack on thinking experienced as a result of working with LD, particularly the more severe and challenging levels.

Our self-care relied much on these two aspects of creativity and personal development, as well as on supportive relationships. It became apparent how important it was in LD work to facilitate thinking about the participants' own wellbeing, as well as that of the clients, hence clinical supervision was so important. It was also important that self-care strategies were tailored to each individual and had a holistic emphasis, and including strategic planning for work-life balance. Art therapists, with their combined artistic and psychotherapeutic characteristics (Gilroy, 1994), have important capacities that other staff may lack, which contribute to their resilience and wellbeing.

Stress management, needed when self-care was insufficient to cope with increased stress from organisational, client-related or personal sources, tended to rely on accessing therapy. Less experienced art therapists needed to develop self-care strategies and to build their resilience and capacity to resist the impact of ongoing stress and change, given the frequency of change in NHS employment.

Next

The Composite Depiction is an overall distillation of the core themes and qualities that I and the art therapists described, discovered in this chapter, and follows next.

Then the final chapter, the Discussion and Conclusion, are presented in Chapter Five.

Composite Depiction



Art therapists in this heuristic study, including the researcher, worked with people with learning disabilities in the NHS and were committed and creative health professionals. They were comfortable working flexibly with people with learning disabilities and made considerable efforts to engage them in therapy. They experienced job satisfaction when helping people with learning disabilities recover from trauma and abuse, using their specialist skills. They also enjoyed working collaboratively with their colleagues, and were person-centred and non-judgmental in their approach. The art therapy process enabled them to work with most clients' disabilities at some level, and the artwork gave the clients ways of expressing thoughts and emotions that they could not necessarily talk about. The artwork clients made varied in its aesthetic quality and could be inspirational and beautiful, or at the other end of the scale destructive, depressing or deadening; consequently the artwork had a varied impact on the participants.

The negative impact of working with the client group was felt as the art therapists were exposed to images and accounts of abuse the clients had suffered and powerful unconscious feelings that they needed to reflect on to help their patients to think about. The countertransference caused the art therapists to feel the same feelings of disempowerment, hopelessness and uselessness as the clients themselves felt; the impact increased with the severity of disability. The work could be slow, the therapeutic alliance difficult to establish, and multiple presenting issues made ending hard. Autistic traits and health problems further complicated the work, and levels of risk and complexity in their caseloads rose. The work was very tiring and emotionally draining.

The art therapists were working in the NHS during a period that was characterised by significant restructuring programmes within NHS organisations. During these staff experienced much uncertainty and anxiety about their job security, changes to their working conditions, intensification of their work, and enormous growth in the size of their organisations and caseloads, in contrast to reductions in the workforce and resources. The processes of restructuring, and particularly of job insecurity, created much occupational stress for the art therapists, although the outcome was favourable, except when their working conditions had become more stressful. The prospect of losing their jobs was difficult for the art therapists because of the limited employment opportunities for their specialised profession.

When they were exposed to multiple stresses from the organisation, as well as the impact of working with powerful unconscious material and feelings from the clients, their stress levels rose and they were at risk of emotional exhaustion. If they were over-committed and worked too much overtime without addressing their needs this had a negative impact on their wellbeing; working in multiple roles (two or more posts), particularly if one was very intense, increased their stress. When these stresses were combined with personal stress, particularly several sources of personal stress, extreme levels of stress were experienced. When the art therapists had high stress levels due to an accumulation of stressors, they were at risk of physical illness, depressed mood, and emotional exhaustion, a component of burnout; however, art therapists who experienced this recovered and experienced personal growth by addressing their needs with stress management. Participants found it was possible to experience considerable stress and recover without illness too, providing they adopted sufficient holistic self-care strategies. Resilience was developed over the duration of their careers.

The art therapists experienced protective factors associated with their creativity, resourcefulness and adaptability when change was demanded. They were flexible, hard-working and resilient; working part-time, when financially viable, was helpful in managing their stress, as were balanced caseloads. Social support available through the NHS, in terms of supportive clinical supervisors, managers, colleagues, teams and advocates for their services all assisted the management of stress when the art therapists were empowered to work with autonomy; when their autonomy or support was compromised, as it could be during times of organisation change, this was another source of stress.

Personal sources of support were extremely important to them and their families were their primary concern. Maintaining their art practice and utilising holistic wellbeing and work-life balance strategies that they implemented was also protective of their health. Personal development was experienced by the art therapists through formal academic courses and learned on the job; they engaged in research, writing for publication, exhibiting artwork, networking and presenting at conferences. These activities acted as an antidote to their exposure to difficulties with thinking and communication that their clients experienced and needed help with, which also impacted them, and were therefore protective and contributed to personal growth.



Next

The Discussion and Conclusion follow in Chapter Five.

Chapter Five

Discussion and Conclusion



5.0 Introduction

In this final chapter I discuss the findings presented in the last chapter, and in Chapter Three, in relation to the research literature presented in Chapter Two. This contextualised heuristic doctoral study is the first British study into the impact of the work of art therapists, addressing client-group specific factors inherent in the work, and organisational factors related to work in a specific nationwide organisation. In addition, the study also considered how the art therapists' personal circumstances impacted their capacity to withstand occupational stress in the workplace.

The study answered the research questions, which asked what the impact was on art therapists working with people with learning disabilities while employed in the NHS, and whether they managed to avoid burnout in their working situations, and if so, how they did that. In aspects related to art therapists and the art therapy profession, as opposed to burnout studies of NHS staff which, apart from Clare (2017), did not specify that they included art therapists, this is the first British study to have addressed them.

Through analysis of the data I discovered how stressed the art therapists were at the point in time when I interviewed them, and themes that related to issues not previously addressed by art therapy research became apparent. As issues related to their physical and emotional wellbeing were explored, factors emerged concerning their employment in the NHS and working with people with LD, particularly during periods of restructuring with consequent changes that had to be accommodated; the art therapists' characteristics in relation to the development of resilience, and the way that personal factors impacted them were also relevant.

The management of stress and stressors in art therapists' working lives were considered, and two approaches identified as necessary through examination of the data: the ongoing maintenance of holistic self-care strategies designed to promote balance in their lives, and the introduction of stress reduction processes when balance was lost and occupational stress increased.

This chapter begins with a discussion of the findings in relation to wellbeing and burnout, including our experiences of job satisfaction; then I discuss factors relevant to the pressures in NHS organisations and working with LD clients, particularly in relation to emotional labour, and personal sources of stress. In the third section I discuss factors relevant to art therapists, such as creativity, resilience and empowerment, their employment, and the profile of the profession. The fourth section addresses protective factors, self-care strategies and stress management; the fifth section considers the application of the heuristic methodology as used in this study, the limitations of this study, recommendations for research and training, and a post-script. The Conclusion follows. After the Conclusion, the Creative Synthesis may be found.

5.1 Wellbeing and Burnout

The study showed that amongst the participants were five who felt they had experienced burnout and pulled back from it, or were aware they could become burnt out if they failed to address it. Lack of understanding of the Burnout dimensions identified by Maslach (1982) was apparent, as they did not seem aware of how it might manifest, or that emotional exhaustion was probably what they were experiencing. Until I looked into burnout because of my colleague's decline I was also unaware of this, as was my Trust, and I was surprised the psychology department we worked within was equally unaware. The official process my colleague experienced before he left his post felt punitive, which remains one of my concerns. A formal recognised diagnosis of burnout, such as Holland and Sweden adopted (Schaufeli et al, 2009; Friberg, 2009), would be beneficial for British workers, I think.

The stressors and protective factors diagram on page 204 showed that there were many stressors on the organisational level, fewer but still many on the client-specific level, and fewer again on the personal level. As stressors stacked up for individuals it was obvious that the more stressors there were on the organisational and client-related levels the

greater their stress would be. However, good support at work was protective, and enabled most participants to keep their stress at manageable levels, which studies by Dallender et al (1999) and Gam et al (2016) and many others found.

As the levels of stress rose in participants, it was evident that stressors had increased and protective factors decreased, showing a direct correlation between protective factors and associated job satisfaction, and a reduction in those factors with an increase in stress and ill-health. This finding is consistent with many occupational stress and burnout studies conducted with NHS and LD staff, such as Appelbaum et al (2000), Blumenthal et al (1998), Dunford et al (2012), Goddard and Palmer (2010), Hastings, Horne and Mitchell (2004), MacIntosh et al (2007), Rose (1995), Sharma et al (2007), Weinberg and Creed (2000).

None of us experienced the burnout dimension of depersonalisation, and there was less experience of this burnout dimension in the few arts therapies burnout studies too (Fowler, 2006; Gam et al, 2016; Hills et al, 2000; Oppenheim, 1987). There was some minor experience of the third burnout dimension of reduced personal accomplishment discussed, which was experienced from time to time when stress overwhelmed participants. It did not stop them functioning in the way my colleague experienced, however, it did have an impact on thinking, organisational and planning capacities, and thus would have been of concern to their managers. Self-awareness is very important when such difficulties are being experienced, as is supportive management. These factors have not been explored amongst British art therapists before.

This study showed that, when significant personal stress factors were added to a great many work-related stressors, this could tip participants into burnout territory. Participants were also more able to cope with occupational stress when their personal protective factors were functioning well than when a key protective factor was missing, such as a supportive partner. It was interesting to note that only two participants felt stress-free both at work and home, following restructuring and study strain; a further two felt stress-free at home but not at work. All the other participants and I had mixed experiences of personal and occupational stress levels at work in our lives, some of which were considerable. Hence this study contributes important information noted by Loretto et al (2005, 2010) and Weinberg and Creed (2000) that is usually omitted in the burnout studies when only work-related factors are considered. The information explored in

burnout studies, if not addressing the power of personal factors at work in workers' lives, is missing a significant component that is relevant to their data, acknowledged by Kozak et al (2013).

I felt somewhat burnt out after leaving the specialist unit, but recovered and developed some resilience to occupational stress; I now know I experienced emotional exhaustion. I was distressed by what happened to my colleague and that had a lasting impact on me as I did not want others I knew to suffer in that way, hence this study. The emotional component of this heuristic study challenged me, as it affected my capacity to think analytically about the data and the impact took a long time to diminish. Eventually I managed to achieve sufficient distance from the psychological impact of experiencing my colleague burn out, and my own experience of emotional exhaustion, to be able to think about it, though of course I continued to experience the occupational and personal stresses and satisfactions described. My creativity and tenacity assisted me to complete this study, but Sela-Smith (2002) considered that introducing participants was a way of avoiding the pain of the issue being studied, which she thought Moustakas (1961/1989) was guilty of. I would contend that this is not the case.

My experience suggests that colleagues' stress and ill-health affects workers, and that the affect can remain for long periods, particularly if there is no beneficial outcome, as in my situation. Participants also experienced difficulties when their colleagues were stressed, some of whom were exhausted, some of whom were unable to be supportive, and some reacted as if in a war zone. When this situation co-existed with stress within my or participants' families, as it did for several, two important sources of support were missing and had the potential to increase stress.

Stress can result in physical illness, according to the literature (such as Taylor and Cooper, 1989; Wentz, 2015; O'Bryan, 2016), and that had a considerable impact on some of us, as two participants experienced life-threatening health conditions, and others experienced symptoms associated with occupational stress, as I had. My colleague also had a long-standing health condition. There was also some experience of depression amongst participants, another aspect noted by the literature as common in NHS staff (Weinberg and Creed, 2000). Thus, concerns discussed in the literature about the impact of occupational stress on health and wellbeing were borne out in my study (Wichert, 2002a; Loretta et al, 2010; Weinberg and Creed, 2000; Nutt and Keville, 2016).

Job satisfaction and burnout may be considered to be on a continuum, but it was notable in the literature review how little job satisfaction was discussed in the LD, NHS or the very few arts therapies' studies. The literature clearly shows that job satisfaction is necessary for wellbeing (Faragher et al, 2005), and it was evident in this study, positively identified in terms of aspects of the work participants and I enjoyed, and aspects of working conditions that were helpful and beneficial. At the most basic level, the participants and I particularly enjoyed working as art therapists and with people with learning disabilities, and found our professional and creative skills further enhanced our experience of our roles.

During times of relatively small organisational changes I and the participants felt happy in our work, developed our practice and engaged in many aspects of personal development which felt invigorating and uplifting; we were able to weather the inherent difficulties of working with the marginalised client group in these circumstances. Such conditions greatly contributed to job satisfaction for us, and our inclination for retaining tenure of our posts for many years in one organisation.

The support we experienced at work and at home was highly beneficial to us, and greatly enhanced our experience of work in the NHS, as did our experience of autonomy and empowerment in our roles, which most participants enjoyed. Being able to work flexibly, change aspects of our practice or conditions to improve work-life balance, and the availability of appropriate resources such as suitable clinical rooms and agile working equipment were also highly beneficial, as was a good income.

We enjoyed the work when we felt we could make a difference, when images were stimulating and interesting, and a good therapeutic alliance was established with clients. We also enjoyed innovative work practices such as developing groups with colleagues or working with staff teams to improve relationships within residential settings. Studies on job satisfaction, such as those by Norcross and Guy (2007), Sousa-Poza and Sousa-Poza (2000) and Faragher et al (2005) considered employment opportunities, income, autonomy, interesting work and supportive work relationships to be extremely important for job satisfaction, and our experiences concurred. Although these factors have been explored in the research literature, they have not been explored with British art therapists before.

5.2 NHS, LD Client and Personal Pressures

In this section, pressures related to employment in the NHS during periods of change, emotional labour involved in art therapy work with LD clients, and personal stressors that added to the occupational stress experienced by participants are discussed.

NHS pressures

The study found that much change was experienced during the period between 2011 and 2013 in my and participants' NHS Trusts, as all except one had experienced restructuring. Stress was experienced during the transformational processes, as all staff in the Trusts experienced uncertainty about the future of their working situations, and anxiety about possibly losing their jobs. Once restructuring was complete, and certainty about their working lives was attained, further processes of adaptation, some of which took a long time to resolve, took place.

Considerable changes in working conditions were then experienced by us as work intensified and reductions in human, work and estate resources resulted from expansion of Trusts, or them being incorporated into larger Trusts. Agile working was introduced to many of the Trusts, office and clinical spaces were reduced, and processes such as hot-desking, room sharing and sourcing, and the provision of agile equipment in the form of laptops or tablets and mobile telephones were experienced by art therapists working in the community (two thirds of the sample and myself). Overall three participants working in inpatient LD services were not impacted adversely by these processes; however, one community-based participant experienced change in every aspect of his post.

The processes of adaptation increased the effort expended by us both physically and psychologically, resulting in fatigue being experienced, and three participants took major decisions to reduce the impact of the changes on their work-life balance, suggesting that the strain they were experiencing was considerable. For some, the stress reduced over time as adaptations were accommodated into their working lives, but for some it increased. Details of how art therapists adapt in occupational situations have not been discussed in the literature before, and the participants were not afraid to make significant changes to their practice and working conditions when they knew it could improve their work-life balance, and consequently their stress levels.

It was evident from this study, and from studies on NHS mergers that were discussed in the literature review (Goddard and Palmer, 2010; Loretto et al, 2010; MacIntosh et al, 2007; Marshall and Olphert, 2008), that staff stress levels rose during restructuring and in some organisations continued to be high afterwards. It was also evident from the study by MacIntosh et al (2007) that not all mergers were successful, and several participants noted that they had been through successive restructuring processes in their Trusts over the years in which they had been employed, as I have. Goddard and Palmer (2010) showed that change processes took time to integrate across merged organisations, and two participants were affected by their LD services being put up for re-tendering every two years, thus perpetuating the stress each time, and in anticipation of this process.

Taking some control over our situations assisted some of us to manage the occupational stress that was otherwise inevitable during such enormous upheaval, and our capacities for flexibility, adaptability and strategic thinking were evident in our adoption of strategies to manage change within our posts. Some Trusts managed change better than others, but nevertheless participants ended up feeling change fatigued after multiple experiences of restructuring (MacIntosh et al, 2007).

The study showed that job instability was particularly anxiety-provoking for art therapists because of the lack of employment opportunities available to them, and they knew that if their posts were lost during periods of restructuring in their organisations finding alternative employment would be difficult. The employment situations of several art therapists in this sample of fifteen participants, and myself, was shown to have characteristics that pertain to this lack of employment opportunities (see page 228 for a discussion of this).

Work intensification was felt by participants in terms of growing waiting lists and caseloads, shorter waiting periods imposed, and a significant increase in administrative processes. Work intensification was the subject of a large research study (Burchell et al, 1999) which found there was an impact in terms of increased stress in many areas of employees' lives at work and at home, and work intensification increased as working practices changed and became more business orientated, particularly in the NHS (Hudson, 2002a, 2002b; Le Fevre et al, 2014).

Organisational culture was shown to have changed in participants' Trusts, as a financial focus took over senior management concerns, resulting in some very poor care being apparent in some Trusts (Flynn and Citarella, 2013; Francis, 2013; Healthcare Commission, 2006, 2007; Plomin, 2013; Quality Watch, 2014), though not in ours. Attitudes of healthcare professionals were affected by organisational culture, and this was apparent in the endless need to explain art therapy to successive managers, the changing attitudes of colleagues experiencing occupational pressure, a de-humanising attitude in some Trusts resulting in a lack of voice, and Trusts avoiding emotional pain. This last point is reminiscent of Menzies Lyth's research (1988).

The sense of being numbers to higher management instead of people was echoed in the studies by Nutt and Keville (2016) and Marshall and Olphert (2008), and NHS Trusts would do well to take note, if they wish their staff to work at optimum capacity and retain their good will. This *is* what Trusts desire, as their staff were expected to manage increased workloads despite having reduced workforce, resources and estate, as the literature showed (Klein, 2013).

It was also apparent that senior managers could be so focused on the business aspect of their NHS Trust that they were completely cut off from the coal face - from the men and women under their management who provide the care needed by their patients/clients. If this is the case, the very managers who are driving organisational change in NHS Trusts are in danger of so denuding their organisations' resources that the caring business for patients just cannot be provided efficiently by the employees. This is very stressful for workers, and the study showed how this aspect of financial constraint in NHS Trusts was impacting art therapists, and how changes in working conditions, in terms of reductions in resources, can go too far without the awareness of senior management. In terms of processes, such as waiting times, the introduction of tasks not within the employee's remit, and increases in electronic administration systems, the same was true.

Emotional Labour in LD work

Emotional labour is an aspect of art therapists' work that is one of several key factors in their experience of the continuum between job satisfaction and occupational stress in the work they engage in with people, whatever the client group. Art(s) therapists' (and psychotherapists') work is built on the emotional relationship established in the

therapeutic alliance between client and therapist, and therefore art therapy is an emotionally demanding occupation.

This study noted how difficult it was to establish the therapeutic alliance at the start of work with LD clients, due to communication issues, autistic traits, and difficulties trusting people due to trauma experienced by services users. These difficulties were discussed in the literature (Bull and O'Farrell, 2012; Rees 1995; Tipple, 1992).

For art therapists working with people with learning disabilities, there are additional difficulties to the normal emotional aspects of psychodynamic work, due to problems with communication and thinking that are inherent. The difference in the impact on therapists of working with a person with a mild LD as compared to someone with a severe LD, where the impact is greater, was apparent. This was clearly shown in Chapter Three, which explored my experience of working in the specialist unit with people with severe LD and challenging behaviour, and how that exposed me to very considerable difficulties with communication and thinking. Consequently, I experienced much unconscious communication, fear, and other difficult feelings. Ultimately it exposed me to emotional exhaustion, which many LD research studies found in other LD workers (Hastings et al, 2004; Skirrow and Hatton, 2007; Innstrand et al 2002; Lawson and O'Brien, 1994; Hastings, 2002; Rose, 1995; Rose et al, 2013; Søndena et al, 2015).

Emotional ups and downs were apparent as a feature of LD work, because of the many different demands made of therapists each day in their person-centred practice. Previous research found that this is common in work with people with learning disabilities (Ashby, 2004, 2011). Resonance with the therapist's own experiences and empathic responses to client material were issues raised by participants, and were another aspect of the emotional labour of therapy work that participants found demanding.

In psychodynamic work the therapist thinks about what they and the client are feeling and thinking about, and what it means. The levels of unconscious communication in LD work make this approach very necessary and meaningful, but demand constant awareness and mindfulness in the therapist, and the ability to push thoughts of their personal lives out of their minds during therapy sessions. Some participants found that stress could impact their capacity to do that, and aspects of work intensification in NHS Trusts impacted

therapists' capacity to cognitively process the work, however Trusts were not aware of these factors.

The powerful feelings, such as hopelessness, the sense of being de-skilled and disempowered, and of despair, that were pushed into therapists working with people with LD were discussed by participants, as I did in Chapter Three. The strong feelings of being de-skilled seem to be one reason that study-based personal development is popular amongst art therapists working with this client group, and I found that working on this doctoral study was protective of my cognitive functions.

Another aspect of therapist work is listening to accounts of clients' lives and experiences, and the participants discussed the horror of many of those accounts; exposure to feelings of despair, and knowledge of these traumas, can weigh heavily on therapists. These processes can expose therapists to vicarious traumatisation (Pearlman and Saakvitne, 1995), which I was aware of, but I did not find that this syndrome affected this art therapist sample. The lack of development in many LD clients in the forensic population, who were still functioning at very early age levels, was evident, and in my work in the specialist unit.

Destructive image-making also exposed participants to much unconscious communication and difficult countertransference, but image-making could also be protective because it could prevent clients acting out in sessions. Working with images was key to the effectiveness of the work the art therapists engaged in, although the quality of artwork could vary considerably because of the cognitive capacity of clients, and that affected their enjoyment somewhat. It was also key to their resourcefulness, which is discussed in the next section.

Characteristics of LD work, such as the slow pace of work and progress were discussed by participants. Difficulties with comprehension and processing of speech were evident in LD clients, making comprehension hard for the participants too. The endless streams of presenting issues that required attention made ending therapy hard, and was evidence of lack of support in other areas of the LD clients' lives, and of intractable and complex issues experienced. These features of LD work, also noted in the literature (Ashby, 2004, 2011; Sarata, 1974; Mansell, 1995; Skirrow and Harrow, 2007) and in the Autobiographical Chapter, lead to frustration and anger in clients, and similar feelings

were pushed into therapists in a way that was hard to articulate. Peer and clinical supervision was helpful when therapists were impacted by these issues, which could make them feel lost or stuck.

Training in brief therapy was undertaken by several participants to combat this issue, and to facilitate better control of waiting lists, which in turn reduced stress. Complexity and risk increased with increases in caseloads for the participants, and concurrently support in the community lessened due to financial austerity resulting in social avenues closing; these factors increased levels of responsibility the therapists had to carry.

Participants expressed concern and anxiety for services threatened with cuts that were needed by the marginalised and vulnerable client group. Several participants spoke about their dedication to working with the client group, and even the passion it evoked in them; this commitment resulted in them going the extra mile in their work and making considerable efforts to engage clients and to understand their difficulties. The fact that their organisations did not understand the necessity for thinking about their work was a problem for them, and was also reflected in the literature (Nutt and Keville, 2015).

In 2001 the government introduced person-centred models of care for people with LD (Department of Health, 2001), but this approach continued to be difficult for caring staff to adopt after deinstitutionalisation, as shown by the study by Salmon et al (2013), and evident in the work discussed by participants that had to be done with carers to maintain failing placements. Marginalisation of the clients, discussed in the literature (Peckham, 2007; Kavale and Forness, 1996; Morrison and Cosden, 1997), meant that an advocacy role was appropriate in some cases. Art therapists have always worked with a person-centred model, addressing every person as an individual. The skillsets of the art therapists were multiple and complex, work could not be prescriptive, and the art therapists had to think on their feet. Considering the challenges of the client's impeded thinking processes, the powerful unconscious communication, and the difficulties these presented the art therapists with in terms of their own capacity to think, it is more apparent how demanding the role is, as the literature showed (Stack, 1996; Rees, 1995; Tipple, 1992).

Also apparent is how important methods for assisting thinking in LD services are, such as time and room for reflection on the work individually, with colleagues, and with supervisors (Rees, 1998). Trusts seem very unaware of this necessity, and how change

processes can destroy former avenues helpful for processing the work, also evident in the literature (Nutt and Keville, 2016).

In the specialist unit, we used ‘Gentle Teaching’ to manage challenging behaviour non-aversively, as Start’s (2008) participants did. However, fear of assault in LD units, where challenging behaviour was common, was found to lead to emotional exhaustion by researchers (Rose et al, 2013), as it had for me. Although violence was often part of the offenders’ profile it seemed much better controlled in forensic units than in community settings like the one I worked in, borne out in the literature (Hensel et al, 2013; Howard et al, 2009). Research on the impact of work in different settings found that community staff were more compassionate but more prone to stress than forensic workers (Søndenaa et al, 2015). Role ambiguity, which we experienced in the specialist unit as staff misunderstood and undermined our roles and boundaries, was also predictive of burnout (Mansell, 2006), however, the lack of staff understanding of art therapy is common in all settings it seems.

I and six of the participants experienced emotional exhaustion, and in us the exhausting factors inherent in the LD work were added to occupational stress, and to work intensification that increased physical and emotional effort required, and correspondingly increased levels of fatigue experienced. Thus, these combined factors increased the risk of burnout for us.

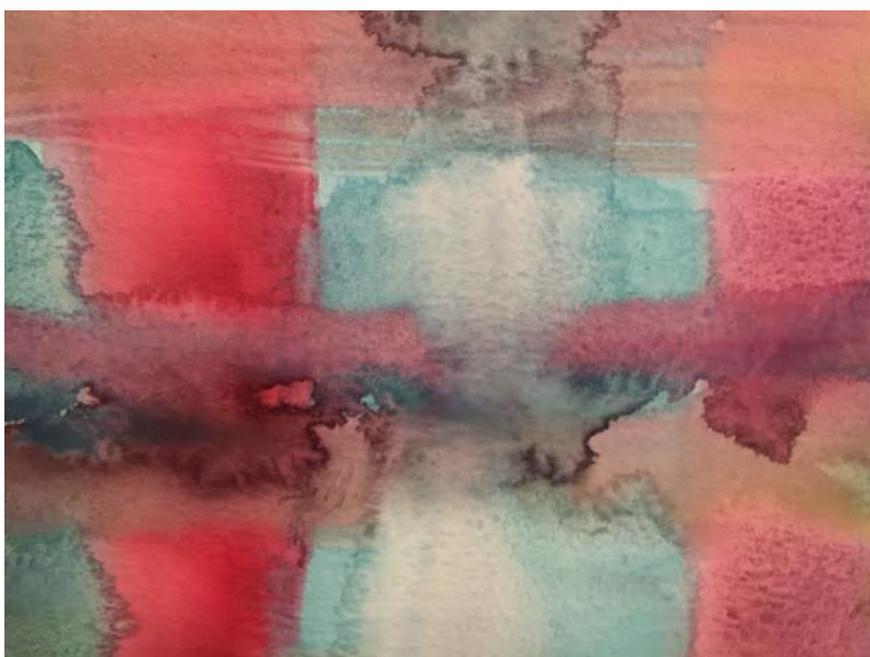


Figure 22: ‘Connecting through the rain’, July 2016

Personal Stress Factors

Personal stress factors discussed by participants were as powerful as their protective qualities, so when present in the art therapists' lives they were hard to cope with. Relational issues were a major component of personal stress, as they were in work relationships, and related to partners, children, parents, close relatives and friends. Just as a supportive partner is very protective of the art therapist's wellbeing, so a relationship breakdown is a very significant loss of protection and exposure to stress. The most stressed participants had all experienced relationship breakdown, and two had children and were divorced, so the repercussions were great and continued for some considerable time. Without the added pressure of the occupational stress these participants experienced, the impact on them of relationship breakdown was sufficient to induce sickness and depression, but each also had to manage the impact of considerable work stressors in addition to these factors. Consequently, each was badly impacted by the occupational stressors and became emotionally exhausted. This concurred with the literature (Wichert, 2002a; Loretto et al, 2005, 2010).

Several other participants were experiencing stress at home, such as bereavement, child, partner or parent illness. Loretto et al (2010) noted that one significant life event made a person vulnerable to mental or physical ill-health, and another significant life event increased the risk. Working part-time and supportive networks assisted these participants to maintain lower stress levels, and all had strategic self-care approaches.

Those art therapists who were least prepared to combat occupational and personal stress also scored highly on the stress levels. More recently qualified participants would have benefited from greater awareness and strategic planning for self-care, and this study will show art therapists how important this approach is. Each had stresses at home as well as protective factors, and the protective factors should have been sufficiently helpful to overcome the occupational stress and reduce their stress levels. However, they were not, it seemed to me, because of insufficient knowledge of the importance of these factors and the need for proactive engagement with them.

Financial considerations had an impact on some of the participants who were major breadwinners, and they were concerned about their job insecurity because of the potential impact on their families. My personal stress factors rose and subsided during the course of my PhD, but reached considerable heights when my marriage broke down, and I

became solely responsible for my children's welfare and keeping a family home. The Autobiographical Chapter revealed many personal stress factors that I weathered, and protective factors I benefited from. Years later I feel a sense of peace and wellbeing that at times in the past I could only hope for. I have, of course, learnt a great deal during this study about maintaining my equilibrium.

5.3 Factors Relevant to Art Therapists

In this section I consider issues relevant to the art therapy profession starting with creativity, resilience and empowerment. Then I address art therapists' employment in the NHS, and the profile of art therapy; these factors have not previously been investigated in British art therapy studies.

Creativity, Resilience and Empowerment

The creative drive was present in all the participants and me, and when able to engage in artistic processes the art therapists greatly benefited in terms of enjoyment, processing of emotion, stimulation and expression beyond words, and when they could not they felt frustrated, guilty and the need to rectify the situation. They enjoyed seeing stimulating and meaningful imagery made by their clients, but found their own capacity was negatively impacted when the artwork and thinking were particularly depressed in the patients. They demonstrated a capacity for resourcefulness and problem-solving, which served them well when adaptations had to be made in situations of organisational change, and in their roles which also had to be flexible to accommodate the many changing presentations of each individual client and their needs. Gilroy (1992) and Tansino's participants (2007) also demonstrated most of these qualities.

Concerns noted in the literature about whether art therapists could maintain their art practice once qualified, researched by prominent art therapist researcher and educator Gilroy (1992, 2004), were evident in some of the participants who found that the demands of their jobs and families prevented desired engagement with their creative processes. Small children brought their own joys, but prevented participants from engaging in activities that reduced their stress, of which their art practice was one. A significant proportion of the participants, however, maintained ongoing art practice and related creative processes.

A relationship between creativity, healing and resilience was apparent in us and discussed in the literature. Resilience was evident in the participants, as those who had felt emotionally exhausted, including me, were able to recover, become more attuned to their health needs and achieve personal growth; some were also able to recover from physical or psychological illness. The study also showed that resilience was developed in an ongoing process throughout a person's career, evident in mine, in some of the participants, and discussed in the literature by Bardot, (2008), Clark (2009), and Sergeant and Laws-Chapman (2012).

Participants showed a capacity to manage stress levels, such as during studies, by putting studies on hold, and when working full-time as lone practitioners and experiencing work intensification. One participant showed considerable resilience as he managed to adapt to a completely different work practice in every way, while experiencing pressure in his personal life. There was also evidence of personal strength arising from new awareness of vulnerability, developing new possibilities, recognition of the need for relationships with others, greater appreciation of life, and a changed outlook on life in those who recovered from emotional exhaustion. These processes were discussed in the literature by Calhoun & Tedesch (2006), Lynch et al (2013) and Gregerson (2007).

Most participants were empowered to make necessary adaptations and to work autonomously, and this capacity greatly increased their enjoyment of their work. In some Trusts managers came and went with some rapidity, particularly during restructuring, and varied as to how supportive they were; participants experienced managers who were empowering and those who were not. The extent to which the art therapists had autonomy and were empowered had a bearing on their physical and mental health and wellbeing, as researchers Laschinger and Finegan (2005), Spence Laschinger et al (2013) and Nutt and Keville (2016), among others, had found.

Art Therapists' Employment in the NHS

Job insecurity is hard for art therapists because there are fewer opportunities for re-employment in their chosen profession and that factor increases anxiety, discussed by Richardson in the BAAT newsletter (2011). Once established in an area and community with a support network, particularly if partners and children are involved, moving to a different area or having to travel long distances for work are not conducive for a good work-life balance.

One participant had experienced redundancy, and the impact of that trauma compounded the anxiety felt in another Trust's change processes, when the participant's post was again under threat; the prolonged job insecurity was detrimental to their health and wellbeing, as research had indicated (Wichert, 2002a). Most participants did experience job insecurity over protracted lengths of time, and reviews that lasted months or even years, and overall the impact was detrimental to all.

One Trust down-banded managers in a de-layering process, discussed by Hudson (2002b), resulting in the loss of experienced arts therapists' posts which were not replaced; the Trust then relied on staff with less experience to do complex work, that increased the pressure they felt considerably and thus stress levels, and there was no direct management to protect them. The literature review showed that Trusts were struggling to retain nurses for the same reasons (Keogh, 2014).

Fortunately, the outcome of restructuring was generally more positive in other Trusts and none of the participants were down-banded or lost their posts, but some vacant art therapy jobs were lost or frozen in Trusts, as they were elsewhere in Britain (Richardson, 2013). In my Trust, at the start of my employment there were nine arts therapies posts, but due to people leaving, their posts were then lost to 'attrition', and now there are only two. There was also evidence of pioneering in recent years which created a few new posts. There was great relief for the majority of the art therapists who had been through job insecurity during restructuring but had not experienced being re-interviewed for their posts and had been retained, however the drawn-out processes took their toll in terms of stress.

As the recession deepened, unemployment benefits declined, eligibility criteria tightened and benefits reduced in duration, with workers being expected to take the first job offered to them rather than seek one suited to their skills. Furthermore, the power of the unions has declined and changes in employment law have lessened protection available to workers (Ladipo & Wilkinson, 2002) as art therapist Ford (2007) experienced. These are very unappealing prospects for art therapists facing potential loss of their post.

The art therapist participants showed a tendency to retain tenure in their Trusts for their entire working lives, as I have, with few moving around, largely because of limited opportunities for promotion, although two participants held head art therapist posts, and

one lead post evolved. Staying could be detrimental to health and wellbeing if conditions do not stabilise for long enough in Trusts, because of the stress involved in ongoing change processes that were evident in the participants' Trusts. The NHS has been subject to ongoing restructuring during the last three decades (Oliver, 2005; Klein, 2013) and many of the participants and their colleagues experienced change fatigue as did the NHS staff in the studies by Goddard and Palmer (2020), Marshall and Olphert (2008) and Nutt and Keville (2016). The recent increase in pension age will also contribute to art therapists staying in posts longer if they are unable to retire on their NHS pensions earlier, as I will have to, noted by the literature (Dore, 1995). This also affects nurses, the majority of whom, like art therapists, are female, and in addition to working longer may have to combine that with caring for elderly parents (Buchan, 1999; Buchan and Seccombe, 2010).

Employment factors for art therapists were evident as sources of stress for some. Full-time work, with overtime, or in two or three jobs, with combined stress from each domain, seemed to be the worst situation for participants. Working part-time, three or four days a week in one post was a protective factor for the participants, but more than one post in part-time hours reduced the efficacy of the protective factor, as seven of us found. Unfortunately, many art therapists are employed part-time and take on more than one post to gain sufficient income for their needs, particularly if they are single or the major breadwinner, thus potentially exposing them to increased levels of stress. Those who had partners that provided another income benefited most, and those who worked fewest days (three was the least). Some participants combined part-time work with childcare, which worked well for them and provided a good work-life balance, and the capacity to work flexible hours was helpful for parents but only one participant could. This factor was borne out in the literature (Sull et al, 2015), whereas particulars related to art therapists' employment have not previously, in relation to occupational stress.

Four participants worked full-time in multiple roles, which resulted in high stress levels for three, but one participant seemed to thrive in such a situation - this participant did not discuss the organisational stresses that the other three experienced, and had a stable home situation, but it seemed that it took a certain type of personality to benefit from so many roles. Some combinations of jobs appear to be more stressful than others, as Wilkinson (2015) noted in relation to the different roles in the NHS. In general working in LD services was not perceived by participants to be as stressful as working in CAMHS, for

instance. There were no apparent stress factors associated with full-time or part-time work per se, however once significant overtime was added the stress began to stack up, and there were signs that one particularly stressful and intense aspect of a job could raise stress levels significantly.

Multiple roles in the same organisation has both advantages and drawbacks, as three of us found, in that there is more flexibility, but it also makes it more likely that one role pressurises the worker to let urgent issues spill over into another role's time. Two participants worked in multiple roles that were not related to each other, and this meant they could have a break from one role when they left at the end of the day; however, one therapist found this was less easy as a lack of facilities in the Trust to aid reflection meant that thoughts of work spilled over to home.

Two participants investigated alternative art therapy employment during the height of the stress in their NHS posts, but found there were no alternatives to follow up. This is a common experience for art therapists, and I also found this to be true, as did art therapists Kyriakidou and Gale (2012), who discussed these issues in a newsletter. Hoping for art therapy work was central to our employment searches, and all the participants were happy to be working as art therapists even if the Trusts were stressful places to work. They valued the contribution their work could make to the lives of people with LD.

The art therapist participants who qualified most recently (between three and seven years ago) experienced problems gaining art therapy employment after qualification, although some short-term locum posts were available. Bearing in mind the financial outlay involved in the professional training, these participants were really worried about the prospect of losing their posts during periods of job insecurity. Health professionals, such as nurses, doctors and psychologists, do not have to bear these training costs, as they are paid by the NHS; in addition, there are more employment opportunities than are available for art therapists – in fact, Kyriakidou and Gale (2012) declared there were no advertised art therapy posts to apply for. Hence the anxiety expressed by the art therapist participants in response to job insecurity was understandable, and appears set to continue in the current atmosphere of financial austerity, as it has done since Edwards wrote about it in 1986.

Research into employment conditions and availability for art therapists would be useful. I believe that BAAT have been collecting statistics for a number of years, and there has also been an HCPC campaign to encourage employers to employ an arts therapist.

Profile of Art Therapy

The literature showed how the profession of Art Therapy was under-resourced and fought for its development within the NHS (Waller, 1991; Edwards, 1986) prior to being granted state registration (Grandison, 1997). Although the profession is now far better resourced it still lacks a robust enough evidence base to easily compete with larger allied health professions and psychological practitioners (Gilroy, 2006; Wright, 2015; Wood, 1999). There has always been a sense that its members needed to be pioneering, as some of the participants were, and to continually work hard at promoting its profile in the health service, which the participants also discussed. Other art therapists discussed this issue in our newsletter (Clement, 2015; Wright, 2015).

Many health professionals lack understanding of what art therapy is, though more media attention was paid to art therapy in recent years, such as the television airing of *Art for Heroes* (2011), and renowned psychoanalyst Peter Fonagy's (2012) endorsement of art therapy as an effective psychological treatment. However, working as a practitioner of a lesser-known profession, with a marginalised client group, inevitably impacted the professional identity of the art therapist participants.

One team discussed working hard to 'de-mystify' art therapy in their Trust and to promote transparency, thus increasing the service's profile, a necessary strategy within the current NHS; demonstrating the flexibility of their practice was a further strategy to future-proof their service. It is likely that part of our role as art therapists will continue to be to promote our profession, either within the workplace, or by conducting research and writing about our experience and expertise, which I and the participants had been doing.

The literature showed that art therapists in each of the previous decades thought their NHS organisations marginalised their work (Edwards, 1986; Mahony, 1992; Rogers, 2002), concurring with some participants' thoughts about marginalisation of the profession currently. However, most of the art therapists in this study felt their work was accepted and valued by their managers, though the discussions about lack of voice suggested that support for the profession did not necessarily go high up in organisations.



Figure 23: 'Rainbow Seashore', October 2016

Appropriate working environments continued to be a difficulty for the participants working in the NHS, and there has been continual pressure on available space since deinstitutionalisation and the introduction of community care, as noted by many art therapists in Hall's (2001) research. The issues continue to pressurise art therapists as recent estate rationalisation further reduced available space, and agile working increased the pressure community art therapists in this study experienced. Participants felt that management did not understand what was needed in the therapeutic space, concurring with Morrison and Anderton's opinion (2007).

The art therapy literature clearly showed how pressure on, or unsuitable, art therapy working environments was experienced as stressful by art therapists (Ford, 2007; Ashby, 2011; Foulds, 1998; Hall, 2001; Morrison and Anderton, 2007) so this study concurred with that literature. Those who were struggling with the loss of art rooms were impacted on several levels, not just in terms of having appropriate space for their client sessions with storage for art materials and client artwork, but also as a space for reflection on the work, and felt the loss of this aspect of their practice.

5.4 Protective Factors, Self-Care and Stress Management

This section addresses factors that were protective against stress from the arenas of professional life explored in this study, within the organisation, the client group and personal factors. Self-care, as discussed by the participants and in the literature, is then discussed, followed by stress management, which was identified in the study as the next stage in addressing occupational stress once art therapists had identified it was necessary.

Organisational Protective Factors

NHS supportive infrastructures were an important aspect of work-related protective factors, and some advocates, managers in participants' Trusts at a higher level, literally saved participants' jobs, and thus contributed to the number of art therapists still able to practice in the NHS. Such managers valued the work of these arts therapists, and prove the point that promoting knowledge of the profession within the workplace is a worthwhile aspect of our role (Wright, 2015), though the need to continually do so for an endless changing picture of management was considered irksome by some participants.

Some of the participants were head or lead art therapists and were very aware of how much support their team members needed. Managers were important for me and the participants in terms of supporting our practice in pragmatic and sensitive ways, particularly our autonomy; when empowered with a budget for training and resources and willing to support our personal development, this was beneficial to me and the participants.

Clinical supervisors, usually more experienced art therapists, were the most uniformly reliable source of support for the participants and me, in addition to their colleagues. Supervisors thought through aspects of our work with clients with us, which was empowering, and particularly necessary when our own thinking processes were impeded by the impact of the countertransference. Peer supervision was useful in this context too. Supervisors were also helpful in discussing organisational dynamics, relationships with colleagues and other staff, discussing stress and health, and relating how all that affected work-life balance. The participants' experiences of supervision concurred with the literature (Edwards, 1986, 1989; Kirk, 1999; Schaverien, 2007; Sonnenberg, 1997; Wichert, 2002a; Wood, 2007).

Nine participants and I worked in arts therapies teams or with another arts therapist, found it supportive, and enjoyed that contact with creative colleagues. I had found it invaluable in the specialist unit (see Chapter Three), particularly when collaborative work was possible, as did some of the participants. Of the six art therapists who were lone practitioners, those that had been for some time found support in psychology teams, whereas those who were new to being lone practitioners missed their former colleagues; professional networking was also helpful.

There were, however, times during which such support was not available, firstly when colleagues felt drained through working with the client group under much pressure, in which case they may have been experiencing compassion fatigue (Figley, 1995), as Simon's team did. Secondly, when all members of a team were feeling stretched and stressed, such as during periods of acute anxiety and job insecurity, and at such times personal sources of support would be even more necessary (Wichert, 2002b).

The organisation of NHS workers into teams, with managers, supervisors and like-minded colleagues is a model that is supportive of their practice and beneficial for their workers. However, work intensification and fragmentation of those teams was shown by this study to reduce their protective functions, and concurred with the literature (Wilkinson, 2015; Wichert, 2002a; Spence Laschinger et al, 2013; Smith et al, 2001; Prowse and Prowse, 2008; Mankelow, 2002).

Part-time work was identified by the participants as a protective factor, as were varied caseloads, which created more balance in the working week and reduced stress, and for part-timers a variety of activities during the week helped to ameliorate occupational stress, so both arrangements seemed protective of health and wellbeing. From a negative perspective, an imbalance in one's caseload raises stress levels, particularly when the therapist is disempowered by the lack of a team manager. Good working environments were extremely helpful, and resources supporting agile working were important. However, too many roles or alternative posts increased rather than reduced stress.

Client-Related Protective Factors

Attitudes that included feeling comfortable working with people who have LD and related difficulties, largely gained from experience, passion for working with this marginalised group of people, and commitment, all played a protective role in the work. For me and

participants, our work with the client group fulfilled existential and altruistic needs and aims (Maccoby, 1980).

Being able to establish a therapeutic alliance with clients, working with people with mild or moderate LD with greater capacity for thinking and communication, and experiencing meaningful imagery, all assisted job satisfaction and enjoyment of the work; so did collaborative work and carer input alongside work with individuals whose placements were at risk. Using art processes to assist communication and achieving good outcomes were satisfying, and the participants sought to empower their clients in the therapeutic process as much as possible.

The protective nature of these factors for art therapists in LD work, and their contribution to wellbeing and job satisfaction has not been discussed in the literature.

Personal Protective Factors

Although there were far fewer personal protective factors on the chart, this fact belied the power of each factor, which was magnified many times above the organisational or client-related factors. A supportive partner was highly beneficial on the protective level, as was the absence of an abusive one. Children in the home situation, supportive parents, and the support of a wider network of good friends were all important to reduce stress, as were a secure home and a sufficient income (Nolan, 2002; Wichert, 2002a).

Though fewer, personal factors were more powerfully protective because of the emotions invested in them and the motivation they provided for successful and continued employment. Personal characteristics of creativity, resourcefulness, flexibility and adaptability, resilience, insight and proactive awareness were shown to be important protective factors (Skovholt, 2001; Plucker et al, 2004; Harter, 2007), and extremely beneficial to our art therapy practice and engagement with change processes.

Self-Care

The art therapists showed that a regularly reviewed, holistic, prioritised and proactive strategy for self-care addressing functioning at home and work was necessary, concurring with Norcross and Guy (2007), however this is not widely known amongst art therapists. The strategy should include maintenance of their art practice (Brown, 2008), a subject much discussed by art therapists (Allen, 1992; Gilroy, 1989, 1992, 2004; Moon, 2002;

Rogers, 2002), and by artist therapists (Harter, 2007; Tansino, 2007). Attention to aspects of work-life balance employed by participants were discussed in the literature (Russell et al, 2007); taking breaks including lunchtimes and holidays, and factors that supported wellbeing and health such as rest, exercise, diet, and additional creative outlets such as studying and music were discussed by the participants, in the self-care literature (Norcross and Guy, 2007; Wicks, 2008; Weiss, 2004; Scheer and Sewell, 2006) and in the arts therapies literature (Hills et al, 2000; Clements-Cortés, 2006).

Etherington (2004b) testified to the beneficial impact of engaging in research, and Meekums (1996) and Sullivan (2005) argued that it was creative. Rees (1995), Stack (1996, 1998), Voorhees (1994), Iype (2010) and I found our research journeys helped us to think about difficult work and were empowering; that much of my PhD process could be done online was also helpful due to geographical distance, as Southernwood (2008) attested. I found that study was protective of my cognitive faculties, and thus is important for art therapists working in LD services, a good proportion of whom also engaged in study (Ashby, 2004). I and participants who had been qualified longer had written for publication, presented at conferences, engaged in research, increased their/our skills both 'on the job' and in formal education. Participants engaged in networking and other continuing professional development activities (CPD), and we found these pursuits to be beneficial.

Stress Management

When stress, occupational or otherwise, was present in the participants' lives, stress management became necessary in addition to the self-care strategy already being employed. The first and foremost aspect for stress management was an awareness of one's need for it (Bardot, 2008; Clark, 2009; Kinnetz, 1988; Urdang, 2010); it was necessary to alert one's support networks both at work and home to one's awareness of stress too. Participants adversely affected by emotional exhaustion took proactive steps to stem the progress of their stress once they were aware of the need, but two became seriously ill before being able to pull that back; it was suggested that it was easy to let one's guard down and become somewhat stressed before realising. Mind-body awareness was advocated by Rothschild (2006) since illness can be caused by stress, and the body is unconsciously activated during therapy sessions. When stress management is needed, this must take the form of interventions. One participant engaged in mindfulness to combat depression, and it clearly can be a useful approach.

However, seeking therapy was the next most important step for most participants and for me, during stressful periods. They sought therapy during their experience of emotional exhaustion, and while good supervision was important and supportive, and could assist with some personal issues, therapy was necessary to go deeper into the issues in a confidential and safe space. Seeking therapy was helpful because stress at home or work tended to reduce the number of people who could offer support, and as art therapists had experience of personal therapy while in training it felt natural to them to come back to it, as the literature suggested (Norcross & Guy, 2007; Sinason, 1997).

Some activities, such as formal study, involved stressful aspects, however, once finished, the stress fell away. How stressful those periods were depended on the level of study, and one participant experienced high levels of stress towards the end of a PhD, but had a strategy to support the team and good support at home; hence, it was important for support to be planned, appropriate and there when needed. Learning in many of the participants seemed protective of their health (Aldridge & Lavender, 2000) as it facilitated thinking and personal development. The importance of maintaining thinking processes through such approaches while working with the LD client group was not discussed in the literature, but was clear in this study. Some participants had to put studying on hold due to stress in their lives, but that was planned.

Art practice was found to be good for healing from illness by participants, and by other art therapists and creative people (Halliday, 1988; Reynolds, 2004; Sibbett, 2005; Van Lith, 2015); it also alleviated symptoms of trauma (Tipka, 1999). The literature discussed how art therapists should not neglect their personal art practice, which is as necessary for our health and wellbeing as a good diet, and that neglecting it can deplete us, leave us feeling disconnected and reduce our personal accomplishment (Brown, 2008; Moon, 2002; Rogers, 2002). Stressed art therapists need to pick up their art materials and address the lack in their lives, as even short periods of creativity reduce stress (Brown, 2008; Sandmire et al, 2012).

Issues in the workplace that had led to occupational stress, such as unsupportive and disempowering management, should be addressed, according to Weinberg and Creed (2000; Mackereth et al, 2005). Workplace wellness initiatives and training were necessary in some Trusts to change 'health culture' (Blake and Lloyd, 2008), and NHS organisational cultures had changed as the business approach took hold; employee

counselling services were offered by some Trusts. The lack of stress management skills included in the KSF were found to be problematic for workers whose managers did not handle their situations well by Lewis et al (2010) and Goddard and Palmer (2010). An increase in social support was needed for stress management in LD settings, according to Skirrow and Hatton (2007), Rose (1995) and Ganster et al (1986), as it is in other settings.

It became apparent to me during the study that self-care strategies were needed by all staff members, at all levels of their career path, as a permanent feature addressing wellbeing and work-life balance. Secondly, it became apparent that stress management involved intervention(s) to be drawn on when the worker became aware that their stress level was rising and needed pulling back; this was not clear in the literature, which tends to put these two aspects together in one category. Thirdly, awareness of burnout needs to be more widely understood in the NHS and amongst art therapists.

The participants showed how important self-care strategies were to maintain wellbeing during difficult times of change and demanding aspects of the normal workload. It seemed that those with less experience had not gained knowledge about this need, and that the more experienced participants gained the knowledge through recovery from periods of stress and/or illness, thus it would seem that training in this aspect of wellbeing maintenance needs to be developed. In my Trust, wellbeing initiatives have begun to be more apparent, suggesting that NHS organisations are becoming more aware of the stress their staff experience.

5.5 Application of the Heuristic Methodology, Limitations, Recommendations and Post-Script

Application of the Heuristic Methodology in this Study

The heuristic methodology developed by Moustakas (1990, 1994) requires the researcher to engage in a painstaking, highly detailed, thematic analysis of the data. This I undertook, drawing on Braun and Clark (2006) and Patton (1990) for more information on thematic analysis, to help me think about how to make sense of the data. I looked at the data sets individually first and then as a whole, considering the themes evident in each aspect, and then how they related to each other. I was somewhat overwhelmed at times by the sheer volume of material, and the limited time I had available during the data analysis phase

also hampered my efforts. My determination and my PhD supervisors also assisted me to stay on task.

This process incorporated three of Moustakas's stages – the immersion, incubation and illumination stages many times over. I have come to think of them as a process rather than 'stages' – because they repeated over and over again. They were also present during the self-search phase (which resulted in Chapter Three and the findings that relate to my personal experience of the issues), during the participants' data analysis stage, and during the Explication phase while the thesis was being brought together, particularly Chapters Four and Five.

Thus, I found that my actual experience of using the heuristic process did not quite follow the pattern Moustakas had described, as Rose and Loewenthal (2006) also found. His six stages involved an initial engagement, immersion, incubation, illumination, explication and creative synthesis. My experience was that initial engagement was the first stage, and the second was analysis of my own data, the self-search, during which the first immersion-incubation-illumination process took place. The third stage was in fact identifying and recruiting the participants, which I called 'participatory engagement'. The fourth stage was one of data generation, involving interviewing the participants and transcribing the voice recordings. The fifth stage of the research was analysis of the participants' data, which also involved an immersion-incubation-illumination process a number of times. The sixth stage was the Explication, identified by Moustakas, during which many iterations of the five chapters that form the thesis were developed, and further immersion-incubation-illumination processes were experienced. His final stage, the Creative Synthesis, did not fit either, as the Explication phase resulted in the Creative Synthesis, which was the thesis, and in a smaller sense the image-poem on page 247, and was the product of a phase or stage, rather than a stage itself.

Moustakas (1990, 1994) outlined a procedure of developing individual depictions or portraits of each participant (see Appendix 6), followed by a process of discovering and unpicking the most important aspects of their individual data sets, and then combining them in a composite depiction (see page 211). This process was helpful in enabling me to move between the individual data sets to holding the entire data set in my mind, with the help of various organisational structures such as mind maps, charts, images and spreadsheets. Participant involvement was also encouraged, and the 'member-checking'

I engaged in fulfilled this aspect of the methodology at different stages of the study. The process he identified as the three immersion, incubation and illumination stages, repeated many times during three stages of the research as discussed, I experienced as natural and invaluable. I also found the self-search method invaluable for analysing my own data, and it would have been hard to do without Moustakas's guidance.

Moustakas's emphasis on a creative approach also made the heuristic methodology a good fit for me, as an artist and art therapist, as it encouraged me to use image-making during my research process, and that was very helpful in a number of ways. Firstly, because the creative drive is so powerful that it is useful to harness it during a period of prolonged study such as this PhD research to assist the capacity to persevere. Secondly, the images assisted the cognitive processes that I needed to engage, and were particularly helpful when I was experiencing the disabling impact of my ongoing art therapy practice with people with LD. Thirdly, the images enabled me to 'think outside the box' when at times that was necessary and I was getting bogged down in descriptive detail with the data and struggling to see the meta-analysis. I was also able to have some fun with my creative practice, and I enjoyed my image-making.

Thus, I found the heuristic methodology did inform my data analysis and subsequent reporting and discussion of the findings in valuable processes, although my understanding of what was happening during the different stages followed a different pattern to that which Moustakas outlined (1990, 1994).

Limitations of the Study

The study would have been further enhanced by using mixed methods, such as a quantitative measure like the MBI (Maslach, 1982), and another measure such as CORE-34 (Evans et al, 2002), to add quantitative data to the valuable qualitative data that has been drawn out of this study. This would have given a definitive figure for stress levels, whereas participants' self-rated stress levels have been discussed in this study.

Initially I had hoped to survey the art therapy profession to measure wellbeing, and consider this in relation to different occupational groups, as discussed in the Methods Chapter. However, a difficult experience during a REC discouraged me, and I abandoned this aspect of my study.

Recommendations

Further research, worldwide, into the impact of the work on art therapists would be beneficial. Most art therapy research is based on practice, and rightly so because of the need for a wider evidence base in order for the profession to be competitive, however the gap in the literature that has been addressed by this study remains a large one. Further research into the impact of working as art therapists in different organisations would be useful, as well as different occupational client groups. A survey of the professional wellbeing of art therapists would also be valuable, especially if repeated from time to time.

Training in burnout recognition, the design of holistic self-care strategies, and related stress management interventions is needed by art therapists, whatever client group, organisation, or employment situation they work with or in: this is also true for all NHS staff, and probably staff in other situations. This study has shown that for art therapists strategies that employ creative processes and promote resilience are the most important for our profession.

Burnout research studies would be enhanced if they included personal variables in their data collection, as a more accurate result concerning stressors and vulnerability to occupational stress can be collected, as this study has shown. A formal diagnosis of burnout would be beneficial for British workers, as has been adopted in Holland and Sweden.

Post-Script

As a short post-script, I wanted to add that when the participants sent me feedback on the findings chapter, many told me that their working conditions had become even harder, and they had experienced more restructuring that had impacted them negatively. One of the art therapists had subsequently been made redundant, and two others left their posts to improve their wellbeing. Two, however, told me that their situations had improved.

5.6 Conclusion

This heuristic study, the first British study into the impact of the work on art therapists, has shown that the art therapist participants and I were exposed to considerable change during restructuring in our NHS Trusts, which intensified our work and put our jobs at risk. The impact of working with people with learning disabilities was experienced particularly in terms of difficulties with our thinking, emotions that were stirred up, establishing a therapeutic alliance, and characteristics of LD clients; the more severe the LD the greater the impact was on the clinician. Agile working was introduced for art therapists working in the community who had the most change to adapt to, and the work was very tiring. It became apparent that art therapists working with people with LD, particularly during periods of job insecurity and related uncertainty and anxiety, are vulnerable to emotional exhaustion, a component of the Maslach (1982) burnout theory. This finding is in line with many NHS and LD burnout studies.

The creativity, flexibility and resourcefulness of the art therapists was shown to be beneficial for their organisations, clients and themselves, in terms of their capacity and willingness to adapt to organisational change, provided appropriate resources were available to support their person-centred therapeutic practice; they were also proficient at producing visual resources, and working collaboratively and innovatively. The participants enjoyed working as art therapists but experienced heightened job insecurity due to the limited alternative employment opportunities for members of the profession; they were highly committed to their roles and enjoyed working with people with LD.

A third of the sample were not stressed or at a low level, a third were moderately stressed, and the remaining third experienced emotional exhaustion or were at risk because of high stress levels. Mental and physical ill-health were also experienced with high levels of stress, however the art therapists showed a capacity to recover and to function afterwards with increased self-awareness, making them resilient employees. It was apparent that resilience developed over time alongside personal growth, concurring with the literature.

Stressors and protective factors at organisational, client-related and personal levels were identified, and a correlation found between increased stress and a decrease in protective factors, leading to vulnerability for burnout, and in contrast a correlation between job satisfaction and health. The study shows the importance of including personal variables in studies of occupational stress, burnout, job satisfaction, wellbeing and resilience due

to the powerful qualities of personal protective factors and stressors; studies that fail to include these variables do not develop a holistic view of the data, which is the case for most burnout studies.

The study showed, too, that there is a lack of art therapy research addressing the occupational wellbeing of art therapists. Some of the art therapist participants were proactive and strategic in their self-care approaches, showing the importance of NHS staff developing individual self-care strategies, and of engaging in stress management if necessary; some participants needed to adopt these practices. This study addresses the gap in knowledge and shows that more art therapy research into workplace stress is needed, as is more training on self-care and management of stress. This study is the first in Britain to address that gap.

NHS workers would benefit from Britain adopting burnout as a diagnosis, and NHS staff need training in recognising the components of burnout; stress management strategies need to be adopted by NHS Trusts, in which burnout recovery is addressed, as this study has shown that recovery is achievable. This is particularly necessary for long-serving NHS staff who deserve care from their management in recognition of their commitment; the study showed that art therapists hold tenure of their posts for long periods. Higher management contemplating change processes in their Trusts need to risk assess for occupational stress in their staff before embarking on change processes, and to take a long-term view rather than taking short-term action that realises little benefit.

I question the wisdom of exposing NHS staff to constant stress, and ask whether changing the boundaries, working conditions and systems within NHS organisations so often does actually make them function better and realise cost-savings? In addition, since prolonged occupational stress impacts health and wellbeing, does it make sense to expose NHS staff to so much stress that it makes them ill? Subsequently they need to access the NHS's services themselves as patients, thus reducing the number of staff in work, increasing the pressure on those who are left, and increasing the number of chronic diseases that need treating and the costs involved – does this make any sense? I would assert that it does not.

The study has identified that art therapists are resilient but they, and other NHS staff groups, need to adopt self-care plans that are protective of their wellbeing, and strategies

for stress management need to be implemented by NHS Trusts for staff experiencing rising levels of stress, especially given the ongoing nature of change in the NHS.

This research offers valuable knowledge about art therapist wellbeing, and shows there is a need for strategies to be adopted into general art therapy practice, and for the profession to raise awareness among art therapists about their need to protect their wellbeing and attend to self-care practices. This is important for all art therapists who are working with emotional material in art therapy practice, whatever client group or organisation they work in, even if self-employed. Information relevant to the impact of different working patterns related to the employment issues of the profession are also useful for art therapists to have awareness of, as well as how to recognise burnout and recover if affected.

Managers of art therapists also need to be informed about the needs of practitioners under their line management, and to be able to offer supportive guidance within the demands of the organisation. Clinical supervisors, who are ideally placed to assist art therapists to think about their wellbeing and consider how the practice they are discussing in supervision is affecting them, need to be informed about the likely impact of the supervisee's art therapy practice. Wellbeing should be a key component of supervisory practice if art therapists are to remain able to function at their best long-term and this has not been discussed sufficiently in the literature.

The research particularly informs the practice of art therapists working with people with learning disabilities and the impact of the work on their wellbeing, especially their cognitive processes. Physical and emotional wellbeing were shown to be impacted by art therapy practice, and when the therapist's cognitive functions are impacted by work with people with LD it can be hard to think about their own wellbeing or put self-care or stress management processes into place. Consequently, the research shows that putting strategies into place as a standard aspect of art therapy practice, whether in LD services or elsewhere, is necessary, so that when stress levels are rising there are already strategies to combat pressure on the clinician.

As the training institutions are where understanding of art therapy practice is laid down for beginning art therapists, this research needs to be disseminated at the start of their

careers, in order for good strategies to be adopted from the outset of their art therapy practice.

Next

The Creative Synthesis follows this chapter. Moustakas (1990) encouraged researchers to produce a creative synthesis of their research material, which one could argue is represented in its fullness in this thesis. However, a more creative expression, such as in a poem, image or other creative form was also suggested.

I explored several ideas for the Creative Synthesis and eventually created a poem addressed to Howard, my colleague who burnt out, which incorporates many of the ideas, themes and qualities drawn out of this research study. The poem expresses my desire to save Howard from his fate, which I had been unable to, and my continuing quest to assist others to understand how to avoid the fate of burning out as a result of occupational stress.

The poem is shown on an image of a 'quilt' ('Complex Quilt – Multi 5', September 2016) created during the process of the research, one of several I created during this time. The 'quilt' contains the idea of many themes co-existing side-by-side at any one time, which are dynamic and active, in the colours and shapes it consists of. The image, when shown on a blue background appears mostly blue, and on other coloured backgrounds a similar experience occurs, and could be considered to speak about bias and influence as well. Thus, it embodies the idea of a living organism of colour and concept, that changes depending on how it is viewed.

Then

The Bibliography and Appendices follow the Creative Synthesis and draw the thesis to a close.

Creative Synthesis

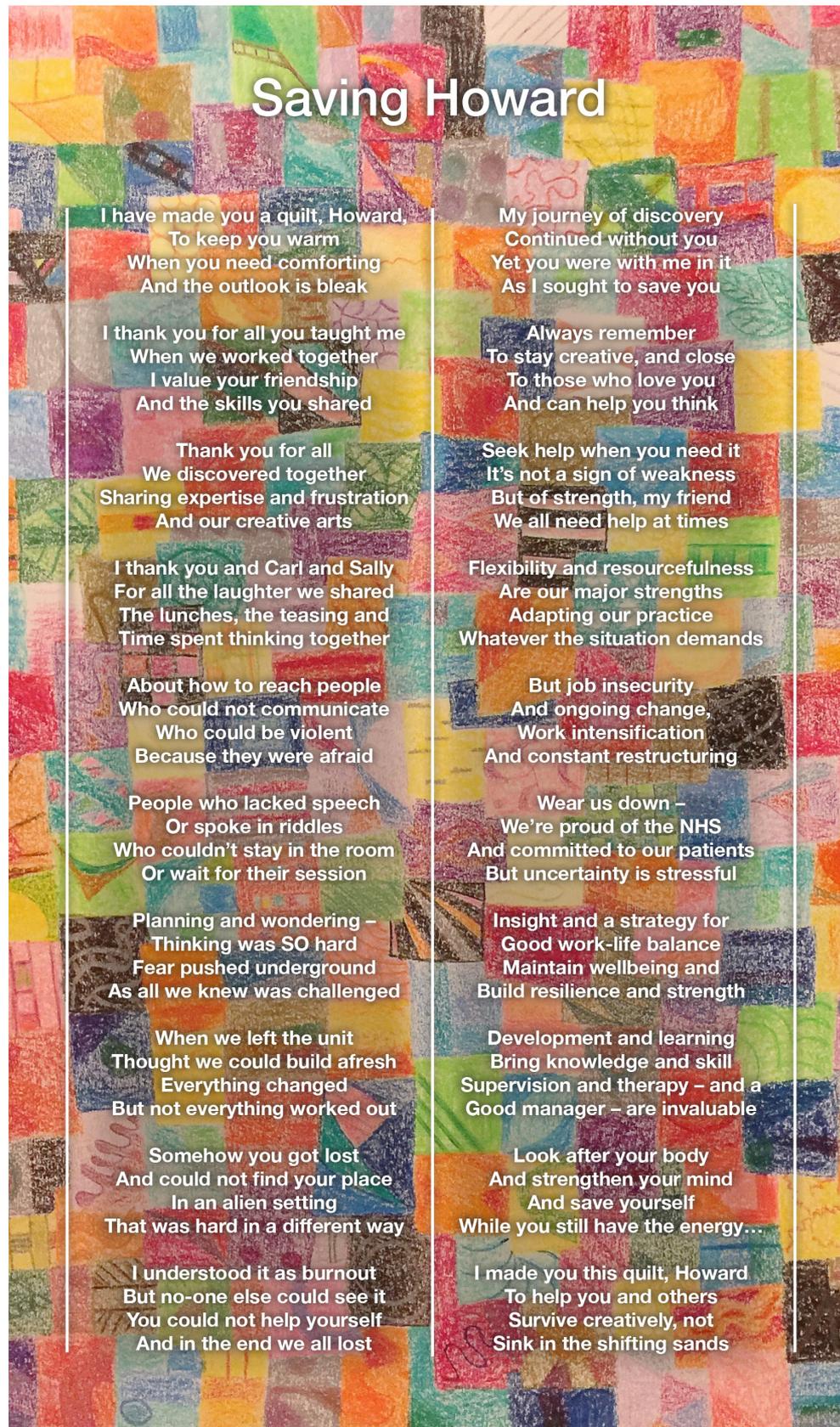


Figure 24: Poem 'Saving Howard' on image 'Complex Quilt – Multi 5', September 2016

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Appendices

Appendix 1: Invitation Letter

Date
Name
Address

Ms. Liz Ashby,
Lead Art Psychotherapist,
Psychological Services (LD),


Dear [Name]

Re: Participation in the study 'An investigation into occupational stress and burnout in art therapists who work with people who have learning disabilities and are employed in the NHS'

Thank you for contacting me and indicating your willingness to be interviewed for the research I am undertaking for my PhD. I enclose a copy of the Participant Information Sheet which explains what will happen in the interview and the process of the research.

I also enclose a copy of the Consent Form we will use, so that you will know what you will be required to give consent to at the interview. In addition, I enclose a copy of the Interview Schedule, which shows you how the interview will be conducted and the issues I will ask you to talk about.

Please read the enclosed documents carefully and contact me to let me know if you are still willing to participate, or let me know if you are not. I will be very happy to answer any questions you may have about the study, the information I have provided or your participation.

If you are willing to be interviewed please let me know and we can make arrangements to meet for the interview. Before the interview can take place, however, I will have to ensure I have R&D approval from your local NHS Research & Development department, which could take about 4 weeks, so we would need to arrange for it to take place after approval has been granted.

I look forward to meeting you, and many thanks for your participation.
Yours sincerely,

Liz Ashby, Art Psychotherapist
The Researcher

Appendix 2: Participant Information Sheet

Participant Information Sheet

Study title

'An Investigation into Occupational Stress and Burnout in Art Therapists who work with people who have learning disabilities and are employed in the NHS'

Thank you for contacting me (the researcher) to let me know you are interested in taking part in this study. This information sheet gives you information about the study: Part 1 tells you the purpose of the study and what will happen if you participate. Part 2 gives you more detailed information about the conduct of the study. When you have read all the information you have been sent, I will be happy to answer queries about the study by email or by telephone; do not hesitate to contact me to ask any questions you have.

Part 1

What is the purpose of the study?

The study is part of research for a PhD, and the research is investigating the impact of the work with people who have learning disabilities, and of working in the NHS, on the art therapist (positive and negative). I hope to identify their coping strategies, as well as characteristics of art therapists that may make them resilient or prone to occupational stress. I hope to identify the sources of stress and how the stress impacts the therapist, whether its source is work-related or combined with personal sources of stress.

Do I have to take part?

You have been invited to participate because you contacted me about becoming involved, but your participation is entirely voluntary. You may withdraw from the study at any time without giving a reason.

Who is the researcher?

Liz Ashby is an Art Psychotherapist employed by [REDACTED] (NHS) Trust, and is studying for a PhD at Goldsmiths, University of London, supervised by Dr. Andrea Gilroy.

What will happen if you participate?

You will be asked take part in an interview with me, at a mutually convenient place, such as your office/studio. The interview will be approximately 2 hours long, and will be recorded on a digital voice recorder. It will be semi-structured using 6 questions as guidance (see interview schedule enclosed). Before the interview can take place I will have to ensure I have R&D approval from the relevant Comprehensive Local Research Network, which could take approximately four weeks.

After the interview I will transcribe the recording and send you a copy, with a sheet on which you can record your comments. You will not be identified in the script, as your name will be changed for a pseudonym of your choice. You can withdraw parts of the discussion you do not wish to have included. Further details are supplied in part 2.

When the data from all the interviews has been analysed the findings will be reported in the researcher's PhD thesis (you will be sent a copy of the findings), and in relevant publications.

Will my part in the study be kept confidential?

Yes, I will follow ethical and legal practice and all information about you will be kept strictly confidential. The details of how this will be done are in Part 2.

What are the possible disadvantages of taking part?

The researcher anticipates no disadvantages as a result of taking part. However, you may experience some uncomfortable feelings when you are talking about your experience of occupational stress, but these are expected to dissipate when you go on to talk about your coping strategies. You may need to arrange time out of work, but you can argue this is part of your CPD.

What are the potential benefits of taking part?

I anticipate you will benefit from the opportunity to discuss your issues around occupational stress and how you cope with it, and you may emerge with a better understanding of your need to attend to your own self-care as well as your client's. I believe the study will be of benefit to our profession, in promoting longevity and attention to self-care for art therapists, which is a subject little explored in the literature. You may also find it interesting to be involved in a research project.

What if there is a problem?

Any problems that might arise will be promptly dealt with by me, as will any complaint. You can also address any concerns to my academic supervisor, see Part 2 for details.

Part 2

What if I don't want to continue with the study?

You can withdraw from the study at any time. If you withdraw after an interview has been arranged and ethical approval gained from your Trust, all information about you will be destroyed, maintaining your confidentiality. If you withdraw after participating in an interview or subsequently during the analysis stage, all your personal details, transcript and any other information will be destroyed, maintaining your confidentiality.

When the transcript of the interview recording is sent to you, you have the right to withdraw any parts of the interview you do not wish to be included. Once the research data has been analysed you will have until 31 May 2014 to withdraw any parts of the data, after which it will be included in the PhD thesis and cannot be withdrawn.

How will information about me be kept confidential?

You will not be personally identified in any written parts of the study, such as the transcript of the interview recording or the analysis of the findings. At the start of the interview you will be asked to decide on a pseudonym of your choice and thereafter you will be referred to only by your pseudonym in the study material.

Identifying information, such as your name, address, email address and telephone number will be known only to me, and will be stored on a password-protected memory stick which will be locked in a filing cabinet at my place of work. This information will be stored until 6-12 months after the end of the study and then destroyed by the researcher. No information about you, other than that you supply, will be sought from anyone else.

All electronic research data will be stored on a separate hard drive, password-protected, which will be locked in a filing cabinet at my workplace, as will any paper copies. All research data will be destroyed after a maximum of 10 years after the study has ended.

A copy of the consent form has been included in this information pack. At the start of the interview you and I will read through the consent form and both of us will sign it and retain a copy. You will be asked to give written consent to me making an audio recording of the interview, and you will be asked to sign to indicate you understand what you are agreeing to. Your consent will be sought to include your data in the PhD thesis and subsequent publications, and does not affect your right to withdraw parts of the data if you wish before the deadline for inclusion in the PhD thesis.

What if I feel upset during the interview?

You may feel upset when you talk about any difficult experiences at the start of the interview but I expect you will feel better when you have talked about your coping strategies. If you feel very upset during the interview please tell me; I will contact you after a few days to see how you are. If you feel upset afterwards I would recommend you talk to a friend, family, colleague or your clinical supervisor.

What if there is a problem?

In the first instance, please contact me about any concerns you have about any aspect of the research project. However if you feel you need to talk to someone with more authority, please contact my academic supervisor, Dr. Andrea Gilroy, at Goldsmiths, University of London. Her telephone number is [REDACTED].

What insurance arrangements are in place for the research?

This research study's design, management and conduct are insured by the University of London.

What ethical approval has this study been given?

Ethical approval has been given by the University of London, and R&D approval has been gained from West Midland (South) Comprehensive Local Research Network, as well as your Comprehensive Local Research Networks. I need to ensure this is all in order before we proceed.

What is the research design of this study?

This PhD research uses a heuristic approach, which starts with my personal experience of the phenomenon being investigated, and explores the issues in depth, seeking the views of others who have similar experiences. I hope to interview up to 15 art therapists employed by the NHS, and each interview will be audio recorded and transcribed by me (using the participant's chosen pseudonym to preserve their confidentiality). The transcripts will be sent to the

participants for comments, requests for quotations, and participants may ask for parts to be removed. The data will be analysed using a phenomenological process of immersion and subsequent thematic analysis and your feedback will be sought to ensure accuracy, particularly of your individual and the composite depictions that will be produced. Participants have the right to withdraw parts of the data until they are included in the PhD thesis, by 31 May 2014. The Ph.D will be examined by the University of London, and the findings will be reported in appropriate publications, and at conferences and art therapists' meetings.

Thank you

Many thanks for agreeing to take part in this study. Without your participation and those of fellow participants, this research could not go ahead. I am passionate about assisting fellow art therapists to continue to practice and thrive, and about contributing to the evidence base of our profession.

Researcher contact details:

Email:

Mobile:

By post:

[Redacted contact details]

Appendix 3: Interview Schedule

An Investigation into Occupational Stress and Burnout in Art Therapists who work with people who have learning disabilities and are employed in the NHS

Interview Schedule

1. Meet participant, introduce ourselves and set up recording equipment in venue.
2. Explain purpose and process of interview.
3. Discuss any concerns participant may have.
4. Read through consent form together, ask participant to choose their pseudonym, ensure participant understands what s/he is agreeing to, then both sign and each retain a copy.
5. Start un-structured interview by briefly explaining my own interest in the topic and then asking the questions as appropriate during the course of the interview:
 1. Can you tell me about your experience of stress arising from your work as an art therapist working with people with learning disabilities?
 2. Can you tell me what you find positive and satisfying about your work as an art therapist working with people with learning disabilities?
 3. Can you tell me about your experience of stress arising from your experiences as an employee of the NHS?
 4. Can you tell me what you find positive and satisfying about your experiences as an employee of the NHS?
 5. Can you tell me about how these issues impact your work/life balance?
 6. Can you tell me about your approach to self-care?
6. Bring interview to a close. Ask how participant is feeling and de-brief. If participant seems upset encourage them to talk to the friend, colleague or supervisor they provisionally asked to be available beforehand.
7. Talk about what happens next, about transcribing the interview, sending it to participant for review and discussion, and subsequent sending of the analysis of the findings to the participant.
8. Thank participant for their involvement in the research and leave.

Appendix 4: Consent Form

Title of Project: An investigation into occupational stress and burnout in art therapists who work with people who have learning disabilities and are employed in the NHS

Researcher: Liz Ashby, Art Psychotherapist, PhD candidate (University of London), employed by [REDACTED]

Please tick the boxes below:

I confirm that I have read and understood the information provided in Participant Information Sheet (V 1.0 20/4/12) and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason. I understand, however, that I cannot withdraw the information I provide from the study after 31 December 2013, after which it will be included in the PhD thesis.

I agree to be interviewed for this study, and for the interview to be recorded on a digital voice recorder.

I agree to the information I provide being anonymised to protect my confidentiality through use of a pseudonym of my choice, and that all information I supply for the study will be referred to using this pseudonym.

My preferred pseudonym is

I understand that my personal data will be securely stored separately from my Interview data, in the manner described in the Participant Information Sheet.

I agree to receive a copy of the transcript of the interview which I will read and Comment on within 2 weeks of receipt. I understand I have the right to withdraw parts of the data if I do not wish them to be included at this point and until 31 December 2012, when the data will be included in the PhD thesis.

I agree to read my individual depiction and the composite depiction, and the analysis of the findings in a process called member checking.

I agree to the raw data from my interview being seen by the researcher's academic supervisors My confidentiality will be protected at all times

I agree to the inclusion of information I supply for this study in the PhD thesis once it has been analyzed, and in subsequent publications.

Signature of participant

Date

Signature of researcher

Date

Appendix 5: Self Search

Self search dialogue 28.11.14

NB: A self-search is a discussion between the researcher's selves, enabling self-analysis (see Methodology Chapter for further information, page 52).

Negative bias

ELIZ: Andy, your PhD supervisor, has been concerned about the negative bias that has been apparent in your discussion of your research findings. Why do you think that is happening?

LIZ: I think I saw what she meant most clearly in my last submission of writing about my findings and I did indeed focus more strongly on the negative. What immediately springs to mind, in a free associative kind of way, is the negative outlook my mother had which impacted me in terms of my thinking as I grew up.

ELIZ: I thought you had taken steps to reduce that?

LIZ: Indeed I had - when I was about 22 (years old) one of my friends asked me why I was so negative, and it made me sit up and think about it. I knew at that time that it had become part of me - I had been so exposed to it without any modification from another (such as my absent father) who could have ameliorated it in some way. I knew I needed to address it.

ELIZ: How did you do that?

LIZ: Well, you know I am a committed Christian – so I prayed about it a lot, and actively looked out for it in myself. I determined to change my outlook from negative to as realistic as possible, with a touch of optimism, if possible. It took some time to change my attitude, but eventually persistence paid off and I did generally look on most aspects of life in as realistic way as seemed appropriate – I didn't want to swing the pendulum the other way and become a positivity freak!

ELIZ: Just as well! It seems to me that on the whole you managed to adjust your attitude to life – so I wonder why it is coming out as you write about your findings, and so many years later?

LIZ: Well perhaps it's because I am experiencing so much occupational stress myself, increase in pressure from organisational change, and the fact that it is ongoing and apparently never-ending. I suppose my 'lens' is infected with my own negative feelings – though actually I think I generally keep them at bay. I have to, to survive the everyday experience of it.

ELIZ: That sounds difficult.

LIZ: Well, I suppose it is if I think about it, but generally I push it to the back of my mind and only open the can of worms when I am with someone else who needs to as well, like Sasha (one of my colleagues).

ELIZ: I guess you need to give vent to it occasionally.

LIZ: Generally within the team we do in team meetings when some particularly annoying issue is around – or at times like this, when we our base is being moved AGAIN, in less than a year since the last time... Then the wider team ends up having lots of meetings and sending letters of protest, and we get to air our feelings a bit more publicly.

ELIZ: Are there any other forums for it?

LIZ: Clinical supervision – a lot of the focus of that is on organisational issues, necessarily, as I have to work out how to change my approach each time there is a major organisational change affecting my work in one job or the other.

ELIZ: So are you saying that peers and your clinical supervisor help you to keep your equilibrium most of the time?

LIZ: Yes, I think so, but I am disturbed to see that the containment these avenues of support give me are not preventing my negativity from ‘leaking’ out in my writing.

ELIZ: What can you do about that?

LIZ: I guess I need to be pro-active and ask myself whether I have been balanced in my writing – and my PhD supervisors will pick it up and keep me on track too.

ELIZ: That external check will add to the validity of your findings, but you must be as unbiased as possible.

LIZ: I guess that’s one of the difficulties of doing heuristic research, because it’s something I feel strongly about that is the subject of my investigation.

ELIZ: It’s something all researchers have to be wary of, particularly when they are writing reflexively.

LIZ: Yes, I am glad that I have become more cognisant of the issue in myself.

Appendix 6: Participant portraits

Portrait of Maria

Maria had been working in the same NHS Trust for over 25 years. At the time she was employed four days a week in two posts, AMH and LD. She was a lead art psychotherapist and usually had at least one, sometimes more, trainees on placement with her. She was in the process of a divorce, and was a single parent of one child, and she also was the only child of an elderly parent.

This was my practice interview, the first. Maria seemed extremely angry and had recently lost part of her practice, working with children with LD, a role she had found challenging but enjoyable. Her organisation was in a process of change, with heads of departments leaving (in both posts) and an atmosphere of anxiety about imminent change, the details of which had not been made available (or had not been formulated sufficiently for them to be made available).

Some time before the interview Maria had become extremely unwell with a chest infection which resulted in a very painful hospital intervention, and she had been so ill she nearly died. This was before she started divorce proceedings and she alludes to the relationship having contributed to her ill health. It also made her more careful about looking after herself.

When you become seriously ill your priorities change. I think that's the closest to death I've probably ever been to and it makes you re-evaluate your whole life

She was angry about the loss of art therapy rooms and felt strongly that the venue for therapy made an important contribution to interventions. She talked of the powerlessness of the clients in LD, who lacked a voice and of parallels between the clients and staff in the organisation who also lacked a voice. She was highly committed to her work with clients and said she was in it 'for the long-term' because some of the clients will return on and off during their lives. Her first thought was of a sense of frustration, about not being able to change things for clients enough - her frustration and theirs. She identified a struggle to think that started with the clients and impacted all the staff working in LD, and the need for art therapists to have time to think, which was not appreciated by the organisation.

Maria felt that the organisation did not follow through with its stated values around quality and staff support

Huge PR stuff about how fantastic it will be to be this Foundation Trust and getting all these awards and things, and I'm thinking 'I haven't got a fucking decent room to work in' - who hears that?

E: So basic sorts of needs not being met?

M: Yes. Not being addressed or not thought important.

Maria felt she worked with a very supportive team within the organisation, and that she couldn't do the work in isolation; she felt a lot of responsibility for her clients and that it was necessary to 'stop rescuing'. She identified a lot of deprivation and loss as being within the work, the need to work within the systems around clients, holding a different

boundary to that in AMH work. She said 'I think there can be joy in the work, um, just helping someone voice what they couldn't voice before, or express in some way, can be quite moving' but she also said that it could be very slow and that pressures had grown, caseloads were now heavier -

I think earlier in the year I was very close to the edge. I was feeling very shaky, very anxious, couldn't - oh all sorts - couldn't settle really.

Maria felt anxiety about her job, because nobody really knew what was going to happen within the organisation, sometimes they thought their jobs would be under threat and sometimes they didn't. As a single Mum she felt she needed 'stability' in her life. She felt the staff were 'thinly stretched' and she didn't feel 'well held'. Pressures within the organisation, particularly the loss of her child LD work, had made her feel she was 'failing' her clients and she didn't want to let go of the work she had invested so much in. And she didn't feel her work was valued by the organisation.

She felt she was suffering from a combination of stresses at work and at home and that she had been close to burnout -

I think it's hard work. It's hard to protect yourself as a clinician against the distress of the clients, and the distress of the organisation... So sometimes I go home and I'm quite exhausted.

As a result Maria took herself into therapy, after trying to access counselling through her NHS organisation, who could only offer her 6 sessions. She had reassessed her life, was trying to get divorced and was now in a new and much better relationship, and she engaged in various creative activities to help reduce her stress. These included drumming, dancing, writing, painting and doodling, and keeping something creative going on at home. She talked of the importance of personal relationships, valued her relationships with other women, and was aware of the benefits of taking time out when it was needed. She went for walks and valued nature a great deal. Good supervision and therapy were also necessary.

She was glad not to be working full-time, because of the increased pressures - which included an increase in admin, particularly in information governance which affected how confidential material was stored and involved 'a huge palaver' accessing it, and also pressure caused by problems parking, which often meant being late or missing sessions. Maria highly objected to these issues. She felt that the pressures were so great now that working full-time could 'kill you off!' There was a 'push to do more, more, more'.

Maria felt a burden of responsibility towards her clients - of 'finding a way to help them' whatever sort of referral it was, and said she had learnt to 'say it as it is' even if it's hard. Maria thought she sometimes needed a bit of 'bloody-mindedness' to give herself a break when it was needed, and talked of the impact of unhealthy relationships on the therapist's psyche, as well as on the body -

You know, the death of the body is one thing, but the death of the psyche is hugely major and so I needed to preserve it - and ultimately that's what you have to do... Yes, well therapy, when you get down to basics, is your psyche and the other person's psyche and if you can't preserve your psyche you can't do the work... You can't do anything!
[ironic laugh]

Sometimes, she felt, she had tolerated too much and had needed to learn when 'to stop being a bloody therapist!' Maria said she knew she couldn't tolerate as much stress now as she used to be able to. She recognised she was afraid of further illness, such as cancer, and wanted to be able to enjoy life.

Portrait of Stacey

Stacey was 32 and had been qualified for three years. At the time of the interview she was working as a locum art therapist for maternity cover three days a week in a Trust that had been through a lot of change and had become a social enterprise. This was in fact her second locum position with this Trust in the south of England, and she was due to take up a permanent art therapy post in a nearby area shortly, also in a community LD team. In addition to her LD locum post she also had a permanent art therapy post one day a week in an acute LD NHS setting, plus work with an adoption agency on another day.

She had 8 clients on her caseload and had more generic duties too, such as attending meetings and conducting initial assessments, and was part of a team that had music, art and drama therapies. She had a limited time in which she could see her clients due to the length of her locum post, which relieved some pressure in terms of ending with clients – it was out there from the outset.

Because the Trust covered a large area Stacey did a lot of driving, which she said she hated, and admin was an issue because of hot desking and the difficulty of finding somewhere to be and do the admin, which probably affected her differently because she was a locum. There was also the necessity to book rooms and set them up, affecting the quality of the space, and requiring her to carry art materials in her car and wet images. So logistics and admin were ongoing issues.

She only did individual work, no group work. She found logistics tiring, and also the 'emotional weight of working with people who have had horrible things happen to them'. It was slow work, could be exhausting. There was a degree of hopelessness around in her thinking about the work, but also an appreciation when a small breakthrough happened, of beauty, which made it all feel worthwhile. She identified an increase in pressure between locum posts and then she was expected to see more clients in less time, and there were pressures to achieve through-put within shorter time boundaries. This led to a lack of time for reflection about the work, which then led to difficulties processing the material and her taking it home and then needing to process it. And she was very busy. Had good supervision and walking the dog helped with processing the day. She had no time for image-making and that made her feel bad.

Her permanent one day acute post was somewhat chaotic but felt like an anchor point in her life, where everything else was less stable, having had to seek work in the context of a recession, and there was unspoken pressure from her family to be employed as an art therapist. In fact, she seemed to have been very successful at gaining art therapy work. But there was a hiccup with her permanent post and a lot of job insecurity and chaos around change in the organisation. There was a sense that that insecurity was around in this organisation too, a sense of what was happening to the NHS politically. Attending interviews and 'selling herself' had been stressful, and there was a financial pressure - could she pay the rent, keep the car on the road?

At the time of the interview she was feeling quite stressed, a combination of work stress and stress at home that amounted to 8 or 9, exacerbated by Christmas preparations but people who know her think she never gets stressed, apparently.

Portrait of Simon

Simon had been qualified for six years and working in the Trust for five; he was married. He was a band 7 permanent member of an arts therapies team. He started working 2 1/2 days a week, and gradually increased to full-time three years ago.

Since the Trust became a social enterprise their team had been without a lead, as the art therapist in that post left because the leads were down-banded from band 8a to 7; there was also a personality clash between her and the department head. The consequence for the team was that no lead was appointed to their team, and Simon was having to attend management-type meetings and a great increase in tasks that would normally not be within his remit. As the only full-time member of the team it often fell to him to attend a meeting or some task, in addition to the three areas he already had enough to do in (North of the city, South of the city, and children). He did not feel experienced enough to undertake management tasks but was having to step up to them as required, however his confidence has increased when he found that he could managed what he stepped up to do.

As a male therapist he often worked with the more challenging clients, and said there had been an increase in cases of male rape that had come to him. He described some difficult and complex cases he was working with, and how he relied on peer supervision to help him cope with the impact on him of this type of work. Fortunately their team was very supportive. Difficulties with clients engaging were discussed and clients who are aggressive. Since the organisation went through a massive restructuring the workload had greatly increased and the pressure was causing a lot of stress, even the sense that the team was 'desperate' for some reduction in the pressure.

Simon had not managed any image-making recently but got involved in arts events in the city most years. He would like to read more art therapy literature, but despite working very long days (7.30-5.30) he claimed back no TOIL, and found he had no time. He found the lack of time for reflection about his work difficult, exacerbated by the use of electronic notes.

The team had been moved from a good base to one that meant an increase in travel for both therapists and clients, and the rooms were problematic - the one we were in for the interview was subject to a considerable amount of noise and some interruptions. Hot desking meant there was no capacity to work in a quiet space, hence Simon had resorted

to coming in early and leaving late in order to find a quieter environment in which to complete the ever-increasing admin tasks he faced.

There was an atmosphere of anxiety at work because the social enterprise came up for tender again the following year, so staff were worried about what would happen then; this worry meant there was little respite from the insecurity and anxiety the restructuring had caused and the staff were not happy about it - although Simon was glad to continue to be employed.

Simon's stress level was 7 to 8 he thought, very stressed. He often felt overwhelmed by the sheer volume of work to be conquered. He uses his early mornings and late leaving to prepare for the day and process the material that was going round in his head. He had considered dropping a day and working 4 days a week to give him time to concentrate on some art. During a time of stress previously he consulted a therapist and would consider doing so again, but felt he needed to look outside the area in which he lived and worked because he did not want to see someone he would be likely to encounter normally. He thought he would know if he was getting burnt out, and that he had developed some resilience.

Portrait of Stephen

Stephen was 38, and worked full-time as the only art therapist in learning disabilities for a large expanding NHS Trust. He had been negotiating and re-inventing his professional identity and the boundaries of his role for the past 18 months, which had entailed 'enormous change' in his working practice and a 100% increase in the area he covered.

Prior to this period of his art therapy practice he had a close working relationship with another art therapist who worked in the city. They had been very supportive of one another, and had been innovative in producing and editing an important publication for which they had identified a need. His colleague left the NHS after this achievement and Stephen found himself alone and imminently to lose his team and his base. When Stephen started working in the Trust a decade ago there were ten art therapists and trainees that he worked amongst, so the level of loss he had experienced had been phenomenal.

Stephen appeared to be significantly stressed and wanted to talk about it, but seemed in denial of the extent of the problem, however he was able to say

My stress manifests itself in my body, so I've got a pain about here [indicating his left side near or slightly below his waist] ... It's something to do with the digestive system, I'm pretty sure...

E: And how painful is it?

S: Oh, it's probably a one or a two, but it's enough for you to be aware of it. And I think the fact that it's there consistently during the working day...

He was aware of being stressed and having 'fears' but had not consulted a doctor about his physical condition. He felt 'pulled in two directions'. He had some freedom and autonomy to develop the service in a new way, under the supportive management of a psychologist, and had forged a place in a psychology team to combat his professional

isolation. However he found himself under other considerable pressures, such as admin and logistics, which were difficult to manage and keep up with.

The loss of his close art therapy colleague was massive for him and 'overshadowed' all that he could achieve now but he found it hard to think about. She had gone very shortly after the publication had been brought out and the sense I gained was that he had felt so bereft that he gained no pleasure from it and did not think of it in terms of the achievement it so clearly was. During the interview, I sensed that something was seriously amiss and I had to probe a bit before he was able to speak about it. In fact it had been an important milestone in his personal and professional life, and it had underpinned much of his thinking about art therapy with people with learning disabilities.

This related to one of the aspects of his work that he found stressful

I think that in learning disabilities in the community you've got a really wide spectrum of presenting issues and referrals. Just thinking about the mental health stuff, versus the behavioural stuff, and all that lies in between really - it's quite a wide spectrum really. Sometimes I probably feel that I don't know enough, and I think a lot of that is based on consistency. I'm the sort of person that if I'm seeing things consistently, then I'll know about them. But when the spectrum's quite wide and you have to know all these different things, I struggle with that... I think that the fact that it can be quite broad can be quite anxiety-provoking in some ways... I could get quite lost with where I was going with somebody...

He was able to identify that the length of therapy and the likelihood of the presenting issues changing during therapy were two aspects of the work that led to him feeling 'lost', and clearly it felt extremely uncomfortable for him and made him feel 'incompetent'.

The publication had addressed many issues related to the 'wide spectrum' found in LD work and helped him to think about it, but he still felt it was a struggle and that he didn't know enough. Accessing training and changing his approach to a brief therapeutic model was his solution to feeling lost in therapy with LD clients, though I wondered whether with some clients he might have 'thrown the baby out with the bath water' in that LD work is often very slow and the therapeutic relationship needs to be built up over time. With only a brief model to draw on this would not be possible. Thus I think his approach may have been a defence against the discomfort he often felt and the pressures that he was under, as well as a response to the countertransference.

He had been so committed to his art therapy post that he moved his family to the centre of the county and put up with living in temporary accommodation with relatives for a year. This situation had all the attendant difficulties of having little privacy and most of their possessions in storage, but it also facilitated the family living in a more rural setting which they wanted, and facilitated easier access to clients in all parts of the county. When I interviewed him the family were getting ready to move in a few weeks into their long-awaited permanent housing, and consequently he seemed to discount all the stress that had been involved in that situation as he looked ahead to what he hoped would be a significant lessening of his stress when they were settled.

To reinvent his post had meant creating a 'business plan' and addressing myriad issues that needed solutions. These included his professional isolation which was considerable

and a completely new way of working. He accessed training, changed his therapeutic approach (to a brief model), acquired a lease car to facilitate increased driving over greater distances, hired rooms in which to do therapy (having lost his art therapy room), and took art materials with him. Some issues, such as transporting wet artwork and storage of art materials still needed to be addressed and were proving more challenging to overcome.

All within his role that had been familiar, supportive and promoting personal development appears to have been swept away, and the new business-orientated NHS Trust in which he had managed to retain his post had placed massive demands on him. Fortunately his problem-solving had brought him into a psychology team which had given him the support he needed in terms of a sympathetic manager and psychologists who he could work collaboratively and innovatively with

It's more of a concept really... in the 'studio space' there might be four people and it will be co-facilitated by myself and the psychologist... in one way [the studio space] is an active waiting list, but it's also a kind of mini assessment and treatment space

But at a massive cost. The effort had been phenomenal and was relentless - although as one person he felt he could ask for resources and his request would be upheld - he now had no-one to bounce ideas off, and to help him think about his situation.

But I think that's the issue, it's ongoing changes and trying to find solutions for things... I think that's what - that is probably difficult enough to do on its own. And what I am kind of feeling is, that because of the other demands on your time these things...
... it's squeezing in the time at the moment to do that

His coping strategies included taking advantage of natural breaks (such as cancellations) to help him reflect, taking lunch breaks and having time with God to help him focus, exercise, praying, and problem-solving. He hoped to overcome his stress and was actively trying to develop other aspects of his personality, such as humour and decision-making to make himself more effective. His Christian faith was extremely important to him.

Portrait of Jayne

Jayne started her art therapy training 18 years ago, just after having her first child, and found her training an amazing experience. Jayne was the only art therapist working across two teams in CAMHS LD, working with children and adolescents, which she had done since qualifying, in the same Trust. She had experience of other client groups but CAMHS LD was her preferred specialty.

She chose to start her interview talking about her background of childhood neglect and sexual abuse, and its interplay in her work. She had seven years of therapy which she found invaluable, particularly as Jayne had experienced three major periods of moderate depression, and mostly had been able to keep working during these periods with the support of therapy and good supervision. She was aware of her vulnerabilities as a result of her background, which could be both strengths and weaknesses.

Work with children entailed a lot of procedures that must be followed to the letter, and some uncomfortable dynamics could develop with managers when they felt open to scrutiny and a blaming culture could develop. Jayne experienced a very difficult situation last year and it caused her a lot of stress.

She talked of the difficulties LD children regarding not being recognised as reliable witnesses and therefore not being able see their abusers punished; social workers expected therapists to help them to understand their clients and were defended against the pain of the work so that they can be less understanding of the issues.

Jayne did a lot of individual work with LD children, which carried a heavy emotional weight. She understood the need children had to be destructive, and she was very containing and valuing of her child clients. At times there could be a lot of confusion around and not knowing, for her and the child. She also ran a group for adolescents which had a more light-hearted feel about it, focusing on keeping them safe and on developing relationships. This work was a relief after some of the more harrowing abuse work.

Jayne did a lot of driving and covered a large area, over 60 miles a day on average, and 9 therapy venues during the week. Although she had access to an art therapy studio at her base, most of her work happened in schools. Some compromise was needed for work in schools because it was a difficult environment to go back into after what might be a harrowing session (for the child) and the work could be less intense as a consequence, which could be helpful, but also limiting.

Having only worked in this Trust meant that Jayne knew all the staff in her two areas, and despite being the only art therapist (although there are five others in the Trust she had some contact with) she did not feel professionally isolated. She had good contacts within the region and knew the schools she worked in well. Some of the teachers made the job harder and some were very understanding of what she did.

Jayne was very organised about her work, completed her admin on time, and found the resources of agile working assisted with that well. She only did electronic notes but there was no issue about confidentiality with them. She worked over her hours to achieve this but claimed the time back with TOIL, and took breaks during school holidays, which fitted in well with her work.

She planned holidays, practised mindfulness and attended dance therapy, and made her own art when she could. She was comfortable financially, in the last five years, and was not expecting any nasty shocks or fundamental changes in her organisation.

Portrait of Sarah

Sarah had been qualified for 16 years and had worked in the Trust for 13 years within LD services, moving about quite a bit during that time. She was married with 2 children, and moved to her current role in a new integrated inpatient service for children and adolescents about 18 months ago; she worked part-time (18 hours) flexibly - to fit in with the service and with her domestic life.

Sarah described herself as 'risk averse' and hence had chosen to work in the inpatient area of the service (a choice she had consistently made over the years), and this she thought was due to the death of her brother when she was 5, and the family's tendency to be protective as a consequence.

She enjoyed the work she did, and now she saw LD clients as well as those who do not have a learning disability. She tried not to take her work home with her, or to pathologise either her own or her client children. She thought that logistics were the most ongoing stressful part of her week currently, working round shared rooms, fitting in meetings, materials going missing because of shared space and so on. The Trust had grown quite significantly and she felt that all the members of the team were very thinly stretched.

Sarah was part of a supportive arts therapies team which had strong management that was sympathetic to her career history, and she supervised one of the art therapists, being one of the senior members of the team. Unfortunately it was hard for her to see other members of the team because of the location of her base and the part-time nature of their jobs.

She felt the move to management within psychology was good, but started off badly. There had been a strong head of department but she died suddenly, leaving the team very shell-shocked, and Sarah was acting head for a while. She described the lead psychologist at the time as a bully, and this was a very stressful time for her. Around that time a music therapist in the team caused a number of difficulties but eventually left, and a close colleague and friend, an art therapist, became unwell and the situation turned into an unpleasant dismissal case. By then the current head of department had been appointed and he had to deal with the case, but because Sarah was friends with the art therapist it was a difficult situation for her.

Sarah felt that her situation at present was good for her practical needs, thus keeping her stress down - she could collect her children from school and walk the dog - but she kept to her hours carefully. The current 'more for less' culture made it difficult for individuals not to feel guilty about not putting in extra hours, but Sarah had elderly parents who needed her help as well as her own young children to care for. She was aware of a 'shadow' of uncertainty that was around, but felt that her situation was at the time as comfortable as it had ever been. If the situation changed and affected her financially that would become very worrying.

Portrait of Andy

Andy was 42, and was a head art therapist for an arts therapies team in LD within a large Trust. He was married with three children. Andy had been working in the Trust for 9 years and during that time had experienced three organisational restructures. His early experience of management was pretty rocky, with an employment tribunal that he had to face, and he thought he learnt his current robust management style the hard way. That time was one of 'horrific' stress.

Andy enjoyed his work as an art therapist and currently was feeling that he and his team were in a stable and fairly stress-free place, but he had only recently finished a PhD, and during that period he was very stressed, particularly when he was writing up. He thought the team had good structures in place while he was unable to give them the sort of attention he normally did.

He had developed management structures which included an awareness of unconscious dynamics within the team and within the organisation. He was very proactive about promoting art therapy, and measuring outcomes so that their work was transparent, in contrast to the impression that art therapy was a kind of 'alchemy' and shrouded in mystery, which used to be the way other services saw the department before Andy took it in hand.

Andy was keen to develop the members of his team and encouraged personal development through projects, which could involve collaboration between team members.

During the last couple of years there was a major restructuring of the organisation and Andy was very worried about the team being broken up, and he had a Plan B. Fortunately the art therapy service was well supported by the lead psychologist and they emerged as a team intact with rooms (shared with the education department but with negotiated agreements over who used the space when).

Andy had been working with people with learning disabilities for upwards of 15 years, and felt it could be rewarding work. He worked mainly in low and medium secure forensic inpatient settings, and now had more time to take on clients since he finished his PhD. His work was quite specialist, and he worked on enabling clients to move from medium to low secure units.

Andy thought that there will be a move to close inpatient units so he had an eye on developing work in the community too, to 'future-proof' the team, so he could say they can work anywhere with anybody.

On a personal level, he had been on a massive learning curve in the past nine years, but had emerged into a fairly stress-free working environment, the result of some hard won developments within himself and within his team. He said he had survived!

Portrait of Walter

Walter was 33, married with two children, and had two art therapy posts in a very large NHS Trust. He worked with children two days a week, and with people with a learning disability three days a week, and was based on two sites. The Trust he worked for had expanded and been significantly re-organised, which he told me was a very stressful time during which all the staff were stressed and worried about losing their posts. However, art therapy came out of that process well and no art therapists lost their post, so Walter was very aware of how lucky he was to be fully employed as an art therapist. The learning disabilities post in particular was well supported, resourced and fairly autonomous within the Trust.

The positive side to Walter's employment was definitely his learning disabilities role, the fact that he was fully employed, and the excellent resources he had access to. Innovative practice was actively encouraged by his manager, who had developed a culture of promoting personal development in his staff and as a full range of arts therapists - drama, music and dance - were employed there was a rich, diverse and creative environment for therapy. He had good supervision with an art therapist in both jobs.

Despite these positive aspects of his jobs Walter was very stressed when I met with him. When asked to rate it between 0-10 (ten being the highest level of stress) he said

W: Um, I would say seven

E: Seven. So sort of...

W: Quite high! Not ten. Maybe if I was, er -

E: Ten's really bad though

W: Yeah. I guess there's an element of denial about certain things, you know, if I was going to be really in the depressive position

E: Mm?

W: I would probably say 8 or 9...

E: Really?

W: Yeah. If I was gonna be accepting more of my situation, it might be higher

Walter described his art therapy post with children as much more stressful than his LD post, and increasing amounts of admin had become quite a burden to him. The children's post required a lot of child protection paperwork that just could not wait. Of the admin burden he said 'well, I've got to a point where I kind of am ready to declare bankruptcy in certain areas of my job... No, just like, I can't keep up with this'.

The other issue he found very stressful was logistics - getting to places in time, rearranging therapy sessions to fit in meetings and so on. All this resulted in a lack of 'head space' and little time to think about the work.

There are times when I feel a bit rubbish because I've turned up to see somebody twenty minutes later than planned, or I have to rearrange, so that's not the best really... But that's all the logistical stuff rather than therapy stuff, but it really impacts on how much head space you've got for the actual therapy

In short, he was doing too much, more than he could really manage in each of his two jobs.

In his LD post the inpatient work, at this point in time, caused him the fewest logistical issues, because the clients were all on the main site and available to work with because of protected therapeutic time. However, this had only been introduced recently and prior to its introduction it had been hard to engage patients who were immersed in a culture of inertia and hopelessness, and hard for Walter to establish himself as an art therapist on the wards. The ward staff were very affected by the culture and it had a negative impact on therapy work.

Protected therapeutic time had established a new and far more positive culture on the wards and had enabled regular open groups to be established, a presence at MDT meetings, and a closed art and dramatherapy group had been created. Walter particularly found this collaboration very stimulating, effective and encouraging.

He did less individual work with inpatients then because there was an emphasis on getting patients out of hospital as quickly as possible, but the individual work he did he described as being more along traditional art therapy lines, depending on individual ability. He saw clients with a wide range of abilities and issues. He described his work with one man with severe autism and LD with whom he could only work in terms of establishing a basic

level of engagement, but he was happy to have achieved even a small step in terms of change with this client. On the opposite end of the scale he went on to describe work with a man with a mild LD who was capable of articulating and working with the issues that had led to his time in hospital, and who created a body of artwork that showed significant change had taken place. He told me that he loved the art therapy work with clients.

He also did individual work with outpatients in the community, in an innovative project aimed at preventing people with LD being admitted to hospital. This work required him to work in the city, to hire rooms and take the art materials with him (which limited how many materials are available for sessions and thereby the therapy to some extent). He also worked with a brief therapy model; the work was satisfying but the logistics were hard.

So I do sometimes - [laughs] - I do sometimes find myself struggling to shift my approach and going from doing this to that and making sure I am not being the wrong kind of therapist in the wrong kind of place!

He often felt rushed, sometimes forgot to go somewhere that's out of the ordinary because it was not in his head and he struggled to juggle all the conflicting demands on his time. He felt that he was doing far more in two part-time jobs than he would in one full-time post. He valued his supervision, but had few coping strategies to help him manage his stress. He sometimes took his admin from his other post to the LD base, where instead of hot desking they had their own office space, to get some peace and quiet, and he tried to take a few minutes after arriving at a new destination to focus his mind. He had started socialising a bit with other art therapists he met in his other job once a month, which he felt was helpful.

At home the impact of having two small children was such that going out with his wife was almost impossible and he had given up football, which previously he had found helped de-stress him, so he could give his wife a bit of free time away from the children and spend more time with them himself.

Walter was very committed to his work, was rather self-deprecating, and had a great sense of humour. He did have insight into his stress levels and their cause, and as a result of the interview he was able to make some changes, at work and at home, to reduce his stress.

Portrait of Katie

Katie had two posts, one in forensic LD for 2½ days a week, another two days in a youth offending team, and she also worked 1/2 a day for one of the art therapy training courses and co-ordinated a regional group. Katie, 32, was married to another art therapist and expecting her first child, so she was not working currently with clients and was going on maternity leave in a few weeks.

She felt that the youth justice work was more stressful, as it was more chaotic and less contained than her work in the low secure unit. The systems inherent in the forensic work, such as locked doors, guards, personal alarms, risk assessments and so on all worked for her benefit as protective factors. She recognised the need to build a strong working relationship with the staff in the unit, which she felt she had done successfully.

The relational security (the nursing staff) was one of the main factors in keeping her safe doing the work, and team dynamics were also one of the main difficult aspects of the work; as well as being supportive they could be obstructive. The nursing staff were so

well trained that they responded immediately to emergencies like a well oiled machine, from wherever they were, but at times they could be subject to assaults and injuries from the patients, who could be very dangerous.

Her countertransference was another important factor. When she experienced fear she analysed it in the context of the risks and voiced her gut instincts with staff and in reports. She spoke of working with patients who behaved well but with whom she still felt uneasy and she was careful to take every precaution, down to what materials the patients could use, how she dressed, where her alarm was on her body and so on. Being a 'good object' with the patients was a protective factor, and they tended to self-refer. She also used countertransference to understand the work and the unconscious processes such as projections and introjections, and was careful to articulate what was happening in the work in appropriate language management could understand.

She seemed well suited to the work, able to cope with the sort of pressures that were inherent in that environment. She had been in post for 3 years and said she loved it, but the previous post-holder had stayed only 6 months before leaving. Katie was inclined to work phenomenally hard, filling her week with different jobs, and in the recent past she had taken a forensic Master's degree in her 'spare time', which had been very pressured and she had been stressed. She seemed quite driven, but fortunately had an understanding husband. She kept a studio and made art when she could. However she felt that she would have to see how things went when her baby was born as to whether she kept working in so many jobs.

Katie was good at multi-tasking, organisation and being very focused. Changes in the organisation were touched on briefly, and issues with rooms. She spoke of becoming attached to her patients and possibly becoming desensitized to the criminal nature of their offences, as she saw them as individuals with traumatic histories. She also worked with some of the patients' families and with members of staff when they were stressed. For her, the biggest stresses seemed to be dynamics within the team and pressures she put on herself in taking on so much, but either she was in a sort of maternal bubble that was cushioning her from the impact at the time or she was not particularly prone to stress. She found making friends quite easy and felt that relationships at work and away from work were very important.

Portrait of Dan

Dan, 37, was married with one young son, and worked in CAMHS LD as an art therapist three days a week. He had previously, after qualifying three years previously, worked in the adult LD service in a support capacity three days a week, and in the adult LD service as a locum art therapist for 2 years covering maternity leave two days a week. The CAMHS LD job overlapped with locum post for a while, and he spent 8 months in the CAMHS mainstream service too. Currently he combined caring for his son two days a week with his CAMHS LD post. The CAMHS work was very stressful so he felt that two days playing with his son was very helpful in terms of stress relief - protecting him from burnout.

The Trust had been taken over by a bigger Foundation Trust's business division, and this had brought an emphasis away from quality to quantity, had greatly increased the pressure on the staff, and their jobs were being down-banded. He worked in a greatly depleted team at present and amidst enormous pressures, but felt that he was subjected to less as part of the LD team than he would be in the mainstream team - and he was glad he was

not in that team. He expressed a lot of anger about the way the organisation was stripping their resources down - he likened it to the Vikings!

In his CAMHS LD post there was only 20% for art therapy and the rest was more general LD work with children, their parents and the systems in which they were situated. His work with some parents with LD who neglected their children or abused them aroused his anger and distress, particularly as being a Dad made him acutely aware of what these children lacked at home. He had been through a steep learning curve, and had had to learn how to do many generic tasks such as ASD and ADHD assessments. He had also learned Theraplay, which is a form of therapy that works with the child and their parent.

The work itself was pretty intense, and could be a source of satisfaction, but mostly was a source of tremendous pressure, for instance to discharge sooner than they would like. He found the work exhausting but the greater confidence he had in the range of his skills helped him cope with the demands. He had produced visual resources for children with LD which are well used, and he was taking on his first trainee soon.

His wife was very supportive and was also a health professional, however they were subject to a lot of personal stress because they had lost three babies by miscarriage at that point, the last only two days ago. This was a source of distress at work when many colleagues were pregnant and people asked how it was going. Fortunately her parents lived close by and were a great source of support and encouragement for them both (his parents lived abroad so he didn't see much of them). He cherished his time with his son, enjoyed baking and cooking as his creative outlet (and a bit of wood work), not having time to paint or sculpt at that time.

Portrait of Joan

Joan, 34, was married with two young children, and was working as the sole art therapist in an adult LD service three days a week. The service had had two full-time art therapists and had been well established, but one of the therapists did not return from maternity leave and Joan chose to work fewer hours. A locum had been employed for a time but Joan was having to come to terms with the possibility she might not have another art therapist to share the work with in the future. She had found these changes very painful.

The level of autonomy had gradually changed over the years and she didn't feel as free to do her own thing as she used to. There have been issues with management being largely absent for some time, and with unsuitable rooms that had to be addressed, at times feeling she had to be quite rebellious about the steps that had to be taken to secure the artwork.

There had been a lot of uncertainty and a lot of change in the organisation, affecting personnel in the art therapy service, in the wider service, in the management, rooms... It felt like the service was disabled, and Joan was unable to plan ahead because of uncertainty about what the service would look like and how it would function - a tremendous amount of stuckness. She had not had her post down-banded, and had been assured it wouldn't be, but others in her team were likely to, and there might end up being two teams in the same room but not working together any more.

She had felt very tired and low and was then finding a way through it, but she also felt shame about the deterioration in the quality of the service, felt a stigma about having a waiting list, although it was due to a lack of personnel. As if she'd let art therapy down. The service had been under review for 18 months with no conclusion yet.

Shortly after the birth of her second child her sister suddenly died, and she took a year to recover and feel able to come back to work, but needed the support of colleagues and a manager, and to be able to say she couldn't manage a particular case yet - and there was no-one who could support her. A lot of LD clients have issues with bereavement and loss and she felt she had to be OK to do that work.

She didn't feel cared for when she came back to work because, having stated in writing to management that she wanted to keep the days and hours she had been working, when she returned they asked her to change them. Also they hadn't told her colleagues what had happened although she asked them to.

She felt the only certainty she had was that she would have a job but even the level of LD that they worked with was changing and becoming more severe. And the uncertainty was throughout the organisation and seemed to be paralysing.

She had been having to try and manage and reduce the waiting list, and although she had some longer-term clients there were others who were receiving brief therapy and she tried to get to them quickly. She said she loved working with the client group, but there wasn't enough time to process the material. She felt an affinity with her clients and felt protective towards them. It was not always necessary for them to gain a conscious understanding of what they're doing, she thought. The variety of the work kept it interesting for her.

She was not in a position to seek work elsewhere because her children are settled in the area, so she was stuck in the organisation even though it was so difficult. She did have a look and see what was out there - nothing.

Working part-time helped her to cope, and friends and family, but not her team because they were all so fragmented, and she missed the close fellowship of another art therapist. In addition, her younger child had disturbed sleep and hospital admissions for breathing difficulties, which had left her feeling more tired than she would otherwise have felt, and therefore feeling she'd been operating on very reduced capacity. The under-resourcing issue led her to feel shame or embarrassment about the waiting list, and it was a parallel to how the LD clients feel about their situations, and there was a difficulty processing and thinking about the work which was also paralleled by the client group.

Portrait of Ruby

Ruby, 50, had been working as the only art therapist for 14 years in a large community LD team with about 34 part-time staff, such as physiotherapists, doctors, nurses etc. Ruby was single and worked three days a week. The team she worked in was under threat of a 46% cut which had been rumbling around for over a year.

The worst aspect of Ruby's job was doing CPA care co-ordination which entailed doing funding applications that took many hours of work and repeated revisions and re-applications. She described it as an absolute nightmare. She did not know why their team had to do these applications, but she became involved with a client whose background was very problematic with his family and who had to be re-housed. The 100 page application went into every detail of the client's life, and Ruby was still expected to see him for art therapy, which she was very unhappy about, but she had decided to withdraw for the next stage of continuing care.

She became extremely stressed, and sought counselling through her workplace. She described herself as having got very burnt out through this case, and assessed her stress level as 9 out of 10. It was a stressful two years.

The art therapy with this autistic client was very repetitive and he went through a destructive phase which put such a strain on the sessions she nearly ended them, but he came through it. She felt overwhelmed, trapped and fearful he would hurt her. It was terrible.

Ruby expressed concern for the future of art therapy, and of the team if they continued to have to do these applications as they wouldn't have time for anything else. And for the clients with mild LD who were threatened with receiving no service despite their vulnerabilities. She was unsure whether she would be made redundant or have her hours cut, but felt the service wouldn't be viable under two days a week. She felt the team was as marginalised as the clients were - a parallel process. She discussed the impact of the work on the therapist's thinking, and feelings of being deskilled, devalued, useless, hopeless, the impact on self-esteem and self worth. She felt she had got stuck in her work for a while, having been in the job for a long time.

Ruby had trainees who helped her run groups, and ran a group for teenagers with severe LD leaving education and their carers, helping the carers engage their clients using art and intensive interaction. Ruby had written a paper about this work, which had very good feedback, and was doing a training day shortly based on it.

On a personal level she was feeling bereft after splitting up from her partner, and she was supporting a friend whose marriage had broken up. Normally she found being able to focus on work helped her cope with personal stress, but when the job was very stressful too that was harder. She had to take one day at a time.

Ruby had kept a studio for the last five years where she made artwork when she was not working, and had enough work for her own exhibition now which was very sustaining. She recently started a private practice, and would like to do more of that. She had found herself wanting to read more theory again, and keep the academic side going - she had a chapter published following taking an MRes. And she started some positive thinking exercises recently - a bit of CBT on herself, and had gone back into personal therapy. She felt she was at a bit of a crossroads in her life, and recognised that she had been going through some personal growth/development as a result of her crises, and working part-time meant that she had time to develop other aspects of her life, such as her art, private practice, writing and delivering training, although money was tight.

The last few years had been hard but now she felt she had backup plans and more to look forward to.

Portrait of Rae

Rae (49) was divorced with three teenage children. She worked 3 days a week in a forensic medium secure inpatient LD service, and set the service up from scratch, alongside a music therapist. She managed a team. It was her first experience of LD work, having worked with adolescents with special needs before and on one of the art therapy training courses.

The clients at first refused to attend a new art and music therapy group, giving the therapists a taste of a powerful feeling of being invisible. The art materials and musical instruments hadn't arrived when they started to add to the difficulties. But the art therapy group was now one of the best attended, was a core intervention and Rae felt good about her work. But the LD clients would kick off for attention. The unit was run like a family - 'we make them nice', but they were vulnerable when they were discharged and likely to re-offend.

The impact of the work was considerable (but came on top of considerable personal difficulties spanning 5 years which have impacted her coping capacity). Running up to Christmas Rae was operating under tremendous projections from the clients and feelings of guilt which resulted in her not booking enough leave, and then becoming so exhausted she virtually collapsed and had to be told to go home and rest. However, while she was unable to do that for herself she could do it for her team. Her manager did that for her.

Working there had been painful, really difficult and traumatic. She also contracted a kidney infection which she ignored until it became acute.

Rae thought about her work in terms of the LD literature, Tipple, Hopper etc. The clients couldn't identify a thought or a feeling. There was a lot of hopelessness and loss - as an antidote the Trust introduced 'hope therapists'! There was negative impact on her thinking and her art both of which were very blocked, although thinking with others helped

Recently she started a new art therapy service at a category B prison and the difference between the level of functioning between the criminals there and the LD clients was huge. She thought of this work as 'a good day out', whereas they are in fact sadistic criminals with PD. But it's more contained.

She began work in a low secure unit too with sex offenders (with the psychologist), two days a week, but she found that difficult - the ward was chaotic and she felt physically sick when she got there, she started smoking and felt really anxious. She thought this was because she had been made redundant in a very unpleasant way, and in fact had had a very traumatic five years, and was afraid of failing at this post. It did all settle down and she was able to be herself more, much more present and hands on, so now they know who she was and what she did.

During the 5 years of trauma she [details withdrawn to protect confidentiality]. She also started a PhD which felt enormously important to her, particularly in view of the thinking issue at work, but the funding was withdrawn so she could not continue and this felt like a huge loss. She worked phenomenally hard and in addition to all the employed work she did she also had a private practice. She did have some looking after herself coping strategies and benefited from sensitive teenagers and a lovely Mum.

Portrait of Jill

Jill was 49, single, and had been working in the same Trust since she qualified 18 years ago. She was a strategic lead (reporting to the board, hence art therapy had a voice), with responsibility for four music and two art therapists. She worked one day a week as lead, and two days in two teams, long days, and then had four days off. She didn't think she could work full-time because of the stress involved. Two of her staff were on long-term sick, and apart from one of the staff off sick they all worked part-time across five teams,

each having input into two teams and a very large geographic area (an hour's travel between each team base).

She felt that much of her stress was organisational, and the Trust was going through yet another re-structuring (the fourth in five years). Rumours bred fear of job losses, and starting work in a new team was really hard, starting again from scratch for experienced therapists who had been working for a long time in the Trust. There had been a significant depletion in posts, but the connection they had with the university was beneficial.

Some of the therapists were not good at using other spaces, or integrating into a team which caused bad feeling. The two therapists who were off sick were burnt out and their work had suffered, they hadn't been seeing enough clients, had too much supervision and hid in the therapy room rather than liaising with their colleagues.

One of the biggest stresses in the work with clients she identified was working with challenging behaviour and the threat of being hit - they're anxious times, even if staff are in the session to provide back up. But she preferred working with clients with some fight in them than those that are too compliant. She thought the art was a fantastic medium, and that 'in even a short time art therapists can make quite big changes in how staff perceive their clients'. Difficult parents could be stressful, one situation required two of them and they had to visit with the police being aware that they were. But working with a psychologist could be fruitful in that it showed them a different way of working.

There were some art rooms available but a lot of the time rooms had to be found within a reasonable distance of the client's home and they weren't always suitable, but some of them were great. There was stress in finding suitable rooms, and in setting up and clearing up each time. She used a trolley. Messy clients couldn't be seen in GP surgeries. They did have access to rooms in day centres, which were noisy, but could be good sources of further referrals.

Jill got really tired on the days she was working (and worked long hours), and needed a lot of sleep. She had the added stress of her father being seriously ill and that had impacted her capacity to study and engage in research. Her parents lived some distance away and she needed to go there often. She made artwork and did gardening in her spare time.

Jill didn't mind hot desking, she got used to it, but found the Trust requirement to get notes written in 24 hours meant that she had to get back to a base at the end of each day. She chose to move bases and teams to cut down her travelling. Her job was going to change from strategic to professional lead which would change her responsibilities - and make some situations easier to handle, such as the long term sick issues, which were very stressful. However she enjoyed her lead work in other ways, and absolutely loved working with people with learning disabilities - she said it was the best job in the world!

Portrait of Lucy

Lucy (52) had been working with people with learning disabilities for 15 years. She trained as a psychotherapist after becoming an art therapist. She found the continual need to justify what we do as art therapists particularly wearing and frustrating, but found it very beneficial that they had to move from being a department to being integrated into community teams.

Working together with other professionals seemed to be necessary, rather than the therapist working in isolation as used to be the case.

She really enjoyed working systemically with staff, more than with parents as that was more difficult, but staff had more of an investment in working through issues. Working with clients in therapy was 'very long, slow digestion of problems... and finding ways to put words into feelings' which Lucy felt would be very difficult if that was all she was doing. She found the combination of working with staff groups and with clients very rewarding and stimulating. One of the difficulties with clients was forming a working alliance, but a mixture of approaches could help, such as seeing clients more than once a week, and seeing their staff too.

Lucy's training as a psychotherapist, after working as an art therapist for a time, had given Lucy a different perspective on her work. More as a patient, and as someone who felt it was better not to be too potent a helper. She felt very enriched by having had that additional training. It was stimulating but very anxiety-provoking too, and unconsciously chosen as opposed to an orthodox route.

She thought that most learning happened through breakdown and failure, rather than the omnipotent thinking that we learn through achievement and success. And that a damaged helper was more useful for a damaged client than a very potent one.

There was a struggle to get band 8 which they didn't manage, and now she thought it was good because the psychotherapists who did later got disbanded (did she mean down-banded?!). The worst experience, though, was with a hostile bullying manager who was 'anti-thought' and was all about numbers and represented complete annihilation of thought (not helpful in a LD setting!).

That experience made her ill, she felt psychically damaged, and she had to take time off to recover, during her training. She emerged more sure of the value of art therapy as her art had helped her recover, and the connection with nature. It changed the nature of her practice and was a big learning curve.

Lucy worked 17 hours across 3 days and also had a private psychotherapy practice, which she felt was necessary to assist her own thinking. She did not think it was good for art therapists to work full-time in LD. She did not feel that much could be achieved in short-term work, that one needed to be in for the long shot. And the necessity of therapists having a long experience of therapy to enable them to think about their internal issues, particularly in response to transference and other unconscious processes.

She felt there was job insecurity fuelled by government cuts and that the NHS was under attack, even going as far as to describe it being similar to a civil war in which people are under pressure. She really disliked being asked to justify her work yet again, and felt she could not cope if the pressure got worse - it had been bad enough over the last few years. However, she said her attitude was positive, that she valued having employment and as long as she could continue to make clinical decisions she would be happy to stay - but not if that was taken away.

Appendix 7: Validation from participants

Received on 8/10/16 from Rae:

It's an extraordinary piece of research, very honest, open, compassionate, descriptive and highly accurate in clearly representing each aspect of the therapist's experience. Very impressive and sobering in equal measure. It's a fascinating read about all the different experiences people have had and the solutions they found to cope with adversity. Says much about resilience.

You managed to capture something that's very complex and tricky to grasp but very important and significant about the impact of the work in LD from every angle. I feel honoured to have been a part of your research and agree wholeheartedly with your findings, not least for myself.

Received on 10/10/16 from Stephen:

It seems to be a very thorough and insightful study that I'm sure will be an invaluable source of information for art therapy in the years to come.

Interesting timing as I've been struggling with stress again lately. I won't go into details simply because it's quite complex...

The house is great. Have just had the double garage converted into a studio/den area. Sometime soon should be dropping a day at work to spend in there every week, producing the most excellent paintings!!

Received from Walter on 10/10/16

The interview did help me think about how I cope with stress, and highlighted my need to be aware of the fact that I am like a big frog in a tank of gradually heating up water.

Katie commented, on 10/10/16

"I'm always in a maternal bubble" and she was in a second period of maternity leave having had a second child.

Received from Jayne on 11/10/16

I agree with how you have written things up- it's very well written- I couldn't see any mistakes at all- most excellent editing!

Thanks Liz – it really is a very valuable reflective thesis- I hope many of us get a chance to read the whole thing when complete.

Best wishes

Received from Joan on 11/10/16

This is an incredible piece of work! I love it, it's both heart-breaking and inspiring. It is really sad to feel the impact of ongoing cost cutting and restructuring on NHS services, clients and clinicians and I wish the politicians who think it's a good idea for the NHS commissioners and providers to be split could read it! It illustrates the impact of the policies of underfunding public services and speaks about what's been happening in the NHS rather than just art therapy or just LD, I think.

On the other hand, it is inspiring and hopeful that art therapists are such a resilient bunch! We adapt and weather the storms and don't lose our value base. And that makes me want to cry but in a different way! I feel really proud to be part of that.

Received from Lucy on 13/10/16

It's a great chapter. The strongest feeling I came away with was 'so it wasn't just me'; I guess this is why you have set out to do this, to gather and present the nature of occupational stress experienced by art therapists, working in L.D.? Because the tendency is to internalise it as a problem within oneself?

It was fascinating and awful to read that most people didn't lose their jobs but the threat of job insecurity recurred as it did pretty constantly for us and each time I got a new manager.

I feel that what I now consider to be sabre rattling was only strengthened by the fact that budgets are constrained not caused by that and that the deeper problem is that of trying to have conversations about psychic pain in public settings, which makes people anxious and hostile.

Are you planning to write something for Inscape in time? I really feel the 'it won't be just you', needs a wider readership.

Warmest wishes and congratulations on much thoughtful, seriously helpful work.

Received from Ruby on 13/10/16

You have worked so hard and made a thorough job of your investigation! It was so interesting to read it. Going through the experience of being interviewed and thinking about my situation at that time probably contributed to my making the decision to [content removed for confidentiality]. It was so interesting to read the interviews of the other ATs and how similar our experiences were at the time- I was interested to hear that I was the only AT having to be a case manager.

Well done Liz- such a helpful exercise in reporting on the often stressful issues pertinent to our often undervalued but thriving against the odds profession..!

Received from Sarah on 13/10/16

Hi Liz, Good to hear from you, and I can only imagine how good it must feel to see the project through to this stage! It is strange revisiting my words from then, it seems like a long time ago. But yes, I guess they do reflect the situation then and whilst it is slightly disconcerting thinking of them recorded and put out there, I guess it's only what our clients experience too.

I found your findings really interesting, all the best for the future! Best wishes

Received from Dan 13/10/16

It looks as though it's been a mammoth project to review and stitch everything together in the clear, logical fashion that you have. It remained a tough read subject matter wise as although I feel in a very different place personally (in a good way), the challenges faced by the profession and organisations as a whole seem under the same or increased pressures. It was also tough to read my own words back as I wasn't at my most articulate when we met, but I'm happy for you to use all the content you shared with me.

Received from Maria 13/10/16

Woah! Wow, a lot of things that are really useful. There is a lot to digest but I reckon many art therapists will be able to relate to it very well, not just those in LD. You have brought together the main themes that will help therapists to make sense of the overwhelming issues at hand. I think your paper voices a lot of what we know which is really useful 'cos art therapists can underestimate what they know, internally and externally, and can contribute.

Great work!

Received from Stacey 15/6/17

It feels like a timely and important document. I was talking with a student who I supervise recently and she was talking about some recent lectures on her course that were focused on 'taking care' of yourself as a therapist. However, she was reflecting that there is not space to do that in her life as a student.

I realised that this is also the case when we work in busy pressured environments and reading this reinforced my noticing of this... My experience has often been that the culture of the organisation is key in supporting people to be aware of stress and the impact of this work on themselves. There have been some great managers who support this, offering good supervision opportunities alongside championing and celebrating the work of the creative therapies in the services.

It feels like this thesis grapples with some of the issues of working as an art therapist working within the NHS, some of these issues feel universal to many client groups and some feel more specific to working with people with learning difficulties.

Well done with finishing it, my experience of talking with people who have completed these documents is that it is hard slog!

Received from Jill 10/6/17

Sorry to take so long to get back to you, it has been horrifically busy.

I think the chapters read really well and are very evocative of how the situation is and the feelings that are around. A lot has changed here within the department, though the environment and organisation is still highly stressed due to the financial situation. The [service] is having to save millions of pounds year on year –[managers] who demand these savings see high cost packages (LD services have one of the highest budgets) but do not understand the cases we have.....they see the pound signs and not the people. There are constant consultations happening and restructuring which leads to redundancies, redeployment - staff morale across the board is low, they are frightened of losing their jobs and don't feel valued and there is a staff exodus, they are leaving for their own well-being, many getting out of health and social care altogether.

Last year we were under threat of consultation and threat of redundancy – following being told our jobs were secure (for the time being) [but] I reconfigured the hours to cover all teams using demographics and have recruited 2 new therapists... The threat of the consultation made [name deleted] leave for her wellbeing, so the majority of the current therapists have been here less than 3 years. The new therapists are enthusiastic, keen, open to flexible ways of working. I made a point of telling them at the end of the consultation period, to look on change as an opportunity to make things work for them. Two teams have relocated and I have received praise from those managers that the art therapists are proactive, flexible and resilient.

The chapters are really great and thought-provoking

Appendix 8: Guide to the Images in this Thesis

Banner headings – each of the banner headings at the start of the chapters is a detail from an image, and closer examination reveals aspects that otherwise would probably have been missed by the viewer (particularly as they were miniature watercolour images). Thus, they mirror some of the analytic processes at work during two phases of the research (the self-search and the analysis of the participant's data) and the discussion of the findings. I also used details of the same image for the Literature Review and the Bibliography because its shapes reminded me of books, and both were about the details of the literature. Using banner headings was also a device to ground the whole thesis in a creative approach. The images used were a series of small watercolours that form part of a collection, and were executed between March and June 2016, when I was working extremely hard to get the thesis together for submission. The creativity of painting a series of images at such a time assisted me to find some creative release, helped my thinking processes, and generally kept me going.

Images in Chapter One (Art Therapy Practice, Methodology and Research Design)

The six images in this first chapter are all about the processes described in the chapter, although the first, named 'solitary endeavour' is more about how isolated I was feeling working at home for long periods on my own some distance away from the university.

The 'art journaling process' which the image on page 38 is about, was a form of artistic journaling that mirrored the research journal (of which there is a photograph of a detail from a page - the image on page 64); the art journaling image featured some actual text that I had been writing in one of the chapters. Some of my artistic journaling was about processing the impact of the work of the PhD on me, and some of it was poking a bit of fun at the seriousness of the work.

'Mind maps' on page 45 is a photograph of some of my many mind maps, which I found a useful process for thinking about the relationships between different aspects of the work I was engaged on at the time, whether that was the literature I was reading or the data I was analysing.

'Endless paper' on page 53 is a comment on the huge piles of papers I had read, iterations of chapters written and discarded, and the vast pile of data that built up during the analysis. I had taken photographs of the different arrangements of paper while I was working on parts and comparing them; I realised they formed images and patterns, and decided to make a creative image of that process.

The photograph on page 59 shows two large sheets of paper with columns and writing, which was another visual way in which I was trying to gather data together into the themes I eventually decided on.

Images in Chapter Two (Literature Review)

There are four images in this chapter, made between the time when I was writing the literature review, going to the REC, and interviewing the participants. The first image, 'Planes of Vision and Colour' on page 67 was an image taken from a series exploring certain shapes and colour combinations, reminiscent of trees, elements of nature, and hidden aspects hard to discern. The artistic processes seemed to bear some relation to the effort I was making finding literature, reading it and attempting to make sense of what I was reading.

The image on page 85 called ‘the Literature Review’ was a comment on the complex labelling system that at one point was driving me potty as I was trying to create a format for a former iteration of the literature review. I decided to greatly simplify it later.

‘Patterns of Paper Strewn Study’ on page 102 was another image from the series about the volume of paper and mess created during the various processes of the research, also making use of some of the text, and noting patterns I perceived when I looked at it from a distance (a similar process to trying to make sense of the meta-analysis, rather than getting bogged down in the detail of analysis).

‘Acquisition of Knowledge’ on page 116 was created in a similar process to the one about the literature review, and is a comment on the various ideas I was absorbing from reading the occupational stress literature.

Images in Chapter Three (the Autobiographical Chapter)

In the body of the thesis I have only suggested the meanings of the images included in this chapter, apart from the poem-image on page 247. The first image ‘Gold Amongst the Chaos’ was made in 1998, and interestingly there is another image in this chapter that also refers to chaos, made in 2005. It seems that chaos felt present much of the time, and this is probably because of the confusion that arises when working with people with LD, and which is more acute when the level of LD is more acute. ‘Gold Amongst the Chaos’, on page 122, was about being actually deskilled by working with people who could not speak, consequently forcing me to learn new ways to communicate and thus invalidating the skills I brought with me (for instance, my capacity for articulation). However, I was also experiencing support from colleagues which made it all feel so much better.

‘Sky-Change’ on page 128 was made with coloured tissue paper and paint, and was part of another series of images I made using those materials. It did reflect ‘unsettled weather’ – there were difficulties in the organisation of the specialist unit, and difficulties we encountered in the work. There were also difficulties with the working environment in my other post. However, my children were delightful and I was enjoying being a Mum, so other more hopeful aspects were also present in my life.

‘Branching Out on page 132 was made using a printing process and a black and white palette, producing a fragmented image, which speaks of a mixture of difficulties and hopeful aspects apparent at work, particularly new developments.

The image on page 140 called ‘Stress amidst Good News’ was created at a time when my mother was dying and we were making plans to move out of the specialist unit, but I was also nearing the end of the MRes and had discovered new knowledge that was useful for my work. The image was made using felt tips at work with a group of colleagues, and so I was not using the sort of creative process I would normally have engaged in.

‘Out of Chaos’ on page 144 speaks again of chaos, but the colours I used in this image were ones that I loved, so although some difficult things had been happening, there were also good developments, such as gaining promotion.

‘Dark Landscape’ on page 148, created using only charcoal, presents a brooding landscape. This image was made during the time I was transcribing participants’ interviews and communicating with them in the member-checking process (2012). It was evident that the NHS was undergoing a major shift across the nation that felt stressful;

we felt somewhat under attack (my second post was marked for deletion). It was a difficult time in the NHS, but we survived.

Amazingly, by page 160 (and mid-2016), I was able to produce the image called 'Contentment', which speaks of life and work having settled down, and the possibility of the PhD coming to fruition was likely. That was indeed something to celebrate!

Images in Chapter Four (the Findings Chapter)

The first image in this chapter is called 'Voice' (page 170) and is about giving the participants and myself voice, when I and they have not always felt they had a voice in their organisations, just as the clients often need us to represent their voices in our work. This is an important aspect of the heuristic methodology.

There is an informative chart of the Participants' Stress Levels on page 186, which does what the label says and shows the self-reported levels of stress that the participants were experiencing when I interviewed them. This is one of two charts in this chapter.

The image on page 197, called 'Bronze Blue 2' is part of the series of miniature watercolours that the banner headings were derived from, and is my favourite of that series. The colours are rich and reveal something of satisfaction, enjoyment and benefit derived from making art in my own life, and is placed in the chapter where the text is a discussion of the art therapists' facilitation of the use of art in sessions with clients.

The final image in this chapter is the chart on page 204 of the many stressors and the fewer protective factors that were evident through analysis of all the data.

Images in Chapter Five (Discussion and Conclusion)

Both of the two images in this chapter are details of larger watercolour images made after the miniature series, and after I had submitted the entire thesis to my supervisors the first time.

'Connecting through the Rain' on page 225 is a comment on the blood, sweat and tears of the last few years spent working on the thesis, which was extremely hard work, on top of my art therapy practice. Despite the stresses I managed to reach the end destination.

The second image, 'Rainbow Seashore' on page 233, is a much more joyful image that speaks of a hopeful future, an end of endeavour and a peaceful time to come.

The 'Creative Synthesis' poem and image

This is found on page 247, and there is a detailed note about this image on page 246. It brings together an image that was part of a series made at work to encourage clients to use simple techniques that could produce a complex and interesting artwork, with a poem about the issues discussed in the thesis. I did write a couple of other poems and combined them with artwork, and I enjoy poetry though I am not good or practised at it, but it felt like a fitting ending to the discussions in the thesis.