Burnout:

a narrative perspective

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Ros Draper once said 'Burnout happens when people stop responding to feedback' (1992, personal communication). When faced with an unresponsive world, isolation or despair can be a frequent experience. I've been feeling some short-term despair and isolation this last week over some particular power practices at work and unresponsive management! I can also experience a sense of isolation and resentment in the face of injustice and inequality in the outside world. Such disheartenment is stronger when I feel alone in my awareness of unfairness or in my attempts to redress it. And there have been times when it seemed I might have to abandon dreams of making a difference, times when I have faced the spectre of hopelessness.

These are some of my experiences, even though I probably have the best job in the world. For those experiencing persistent despair at work, perhaps overburdened and unsupported, perhaps alone with values and ethics that their agency doesn't seem to share or respect, perhaps with small successes that pass un-noticed and un-acknowledged, leaving might be the only way to survive. That well-known saying, 'people don't leave organisations, they leave managers', reflects the importance of responsiveness rather than just workloads.

Connecting the phenomenon of burnout to responsiveness in relationships contrasts with common ideas in our culture that emphasise the importance of time and activities outside therapy and on maintaining professional boundaries. This latter emphasis reflects a charge-and-discharge orientation to our work, suggesting we give out or charge up others when engaged in therapy, get recharged in our personal lives, and that clear boundaries are required between the two lest some short-circuit or complete discharge occur that requires the deep recharge of going off sick to recover.

But you may also have experienced the uplifting effects when a meeting goes well, and the warm and precious moments when joined in conversation with others who seem to share our own values and purposes in life. I can have days of pleasure after a particularly rewarding encounter and this pleasure has a most anti-burnout feel. These experiences seem to point to the value of blurred boundaries rather than clear boundaries and of personal or even intimate conversations rather than clinical conversations with those who consult us. So how can we understand these experiences when conventional thinking suggests we should keep firm boundaries and maintain a clinical distance? And how can we engage willingly with blurring boundaries and intimate practices without abandoning ethical limits?

rule ethics and relational ethics

As organisations grow and become more regulated, so generalised and pre-set rules (e.g. policies, protocols, codes of ethics) are created to guarantee unified practices and protect the organisation from activities that might lead to damaging legal or public action. Sometimes these rules come from internalising or pathologising ideas e.g. rules of confidentiality have become important because problems tend to speak negatively about a person's identity. What would people think of me as a marital therapist if they knew of my marital problems? This is not to say that confidentiality is a bad thing, just that it arises from a particular discourse.

These rules do not invite us to think about how people are affected by our actions, but that so long as we have conformed to the procedures, our actions are OK. Such thinking ignores how we all struggle with the grey areas of dilemmas posed by competing ethics e.g. how to respond to counter-therapeutic enactments of power between family members without reproducing such practices ourselves.

The rather black and white thinking of rule ethics also promotes the illusion that it's possible to control others from a distance through such rules. I have been powerfully influenced by ideas (Cecchin, Lane & Ray, 1994) suggesting that attempts to control result in inefficiency, violence and corruption. Furthermore, 'When we see a person as needing to be controlled it feeds the madness that one has to control.' This does not mean that anything goes, but that self-created limits, agreed from the give and take of collaboration, are different from one person's attempts to limit another. The foundation for self-limiting collaboration is in creating a context of co-operation, so that children agree to do as they're asked, therapists agree to carry out supervisors' advice etc.

Like someone who takes recourse in 'the truth' to justify their action (e.g. 'this is what you should do as research has shown it to be the best thing') rule ethics can permit us to avoid responsibility for the effects of what we do (Freedman & Combs, 2002).

These practices distance us from those who consult us, as our primary accountability is to the rules, not the person. This can isolate us in the world of therapy and disconnect us from those who seek our help.

therapist as expert

Such isolation and disconnection is exacerbated by the belief that therapists can somehow be detached and knowing observers. Many professional practices (e.g. assessment, evaluation, classification, measurement, treatment) reflect this belief. Devices such as questionnaires (e.g. Connors ADHD, depression scales) pose as 'instruments of truth seeking' (White, 1997) as they locate people on continuums of attention - inattention, depression - happiness, normality - abnormality etc.

Therapists then take up strategies to correct what is thought to be wrong e.g. behavioural advice about appropriate boundaries, interpretations to improve insight, family therapy interventions to restructure relationships on more healthy lines.

These discourses are always close by when things aren't going well and it is entirely predictable that at these times we judge our therapeutic failures using the same scales, and identify the source of the problem as ourselves. The detachment of this expert position separates us further from those who consult us and leaves us more likely to conclude the cause is our own personal failure.

one-way accounts

The common construction of therapy is of a process where we are deemed to possess a knowledge that we apply to the lives of others. Their lives are changed whilst our lives remain the same. This idea obscures how our lives are touched by others, separating their lives and our lives. Our life is ignored as life becomes something that seems to take place elsewhere (White, 1997).

I recall Maria, a young mother who mentioned in passing how she had withdrawn from a long-term heroin habit. This aside took me back to my many efforts to give up smoking and the struggles I went through. From this perspective, her aside about kicking a heroin habit assumed considerable status. I began to wonder what it might be like for her if these skills were more widely known, or available to others, or if she applied these skills in other areas of her life. I felt linked to her in a shared value of living life free from such habits. When I shared with her (in a reflecting team) how struck I was by what she had achieved and how it had resonated with some of my own lesser struggles, she started to cry quietly. I wasn't able to clarify the reason for these tears but I believe my words provided a powerful acknowledgement for her of what she had achieved in giving up this drug habit. Her tears and this very personal connection I felt blurred the clinician/client boundaries between us; indeed it felt intimate, and was an anti-burnout experience for me.

control, illusions and practices of power

I live with extraordinary privilege. This is not just the privilege of knowing there'll be food for tea tonight and money in the bank at the end of the month, but also the privilege of being a white, heterosexual, employed, educated male, living in Western Europe. Such structural and financial power means I can access resources and opportunities and achieve sought-after ends relatively speedily and through simple actions based on my will. I can hire a cleaner to help manage the house, spend money on myself to influence my mood, expect to be noticed and treated fairly when I complain about poor goods and want a refund.

Such singular action is an appealing strategy and favoured for achieving particular agency goals. In attempts to achieve success through singular action we have adopted language from the ethic of control - so we now have case-managers, interventions, strategies, targeted groups, behaviour management and service delivery.

It is unfortunate for agencies that human relationship problems often don't respond to such methods. I cannot manage people or relationships in the same way I manage money or time. We may want to 'manage children's behaviour', for example, but what goes on, and what stands a much greater chance of a good outcome in my view, is more likely to be 'talking to children about their actions'. The possibilities for control through singular action in case-management are about whether we open or close the file, or what we write in it - we cannot really manage clients, nor control their actions, nor the actions of colleagues, whatever language we choose to use. The illusion of influence and manipulation is unavoidable say Cecchin et al (1994), but illusory because we cannot predict what influence we will have. What lasting attitudes or positions might we be fostering through our attempts to control?

When we are informed by an ethic of control we also forget the significance of what we are requesting from a client who does not enjoy similar privileges. Living with the enormous good fortune for example of a stable upbringing, financial security, intact family, and friendship networks, can obscure the enormity of tasks like losing weight, giving up smoking, working collaboratively with an ex-partner, achieving consistency in parenting etc. So when we embark on therapy from such a position we make ourselves highly vulnerable to experiences of failure - *this is the failure to bring about changes to other peoples lives.* And when such professional actions don't work these power practices can distance the client (who will also experience a sense of failure) and can invite us to step further into controlling actions. You may also have attended child protection conferences where parents, having declined professional exhortations to shape up rather than complain, now find themselves getting diagnosed with Munchausen's by proxy i.e. doing things to intentionally damage the child, which 'requires' further control from public authorities.

narrative practices that contribute to connection and responsiveness: contextualising our comments

We can translate expert positions into personal positions by disclosing the context of their production. To 'situate' ideas, comments, suggestions, questions etc is also to describe the history of our relationship with them. This re-positions the idea from a place of truth status to a place of transparent personal and particular interest of the therapist.

So, rather than suggesting a couple spend more time together without the children, because we 'know' that will strengthen their relationship, we can begin to say 'I'm reminded of the idea that spending more time together can help strengthen a relationship.' To disclose the history of our relationship with this idea we would also say something like 'This idea occurs to me because it's become so popular that I have to work hard to think outside of it. However, I do know of times it hasn't worked, times when it's put unbearable pressure on a couple and times when its lack of success seemed to have negative effects on the therapeutic relationship. What do you think?' What was 'advice' has become 'the passing on of ideas'. It's also, in my view, more honest! This constructs power relationships differently and makes situations less vulnerable to those 'I tried what you said and it didn't work' comments.

Disclosing research findings, opinions, advice and all other

comments can be re-constructed in this way. Comments that we weren't accountable for (because we could claim they had truth status) become comments that have personal relevance, not general relevance (White, 2000, ch. 4).

acknowledgement and applause

Practices of acknowledgement e.g. 'I was struck how you did finally manage to leave that relationship, because of my experience with my sister and how the economic and social pressures made it hard for her to leave a violent relationship', can be distinguished from practices of applause e.g. 'That was a huge achievement for you to leave him', 'You must be such a strong and determined person' etc.

Even simple applause like 'Well done!' involves us:

- Establishing a hierarchy of knowledge about what would constitute something being well or poorly done.
- Setting ourselves above the other person on this hierarchy so we can judge their performance.
- Comparing the other person with a (usually invisible) norm.

This practice further contributes to establishing ourselves as experts, thereby separating us from others. Whilst occasionally, hearing a 'Well done' has given me a warm glow, I have also had experiences of feeling patronised, or feeling the other person doesn't understand my standards if they think something was done well. This is not to say that applause is a bad thing, just hazardous.

Practices of acknowledgement can be achieved by asking myself, why do I think this was done well? This question contextualises my sense of someone's achievement into my own life e.g. what you did there felt significant to me because other men have told me how they struggle with this. This renders the comment personal and particular to me, not a generalisation that I apply to others arbitrarily.

taking it back practices

These practices allow us to describe how we have been touched or influenced by those who consult us. Therapy becomes a two-way street as we link our lives with others around shared themes or values. Thus our clients help protect us against the isolation that can lead to burnout.

For example, my education and consciousness of social and structural inequities, and the effects of gender politics have largely been because of the graciousness, openness and patient teaching of:

- Debbie, a single mother and now a practicing social worker, who struggled with her exams at the same time as her children's self-harm, voice-hearing and drug-taking.
- Maria, who opened my eyes to the reality of kicking a drug habit without support.
- Dave, 15 years, who is managing to forgive and rebuild significant relationships despite the most terrible abuse, neglect and betrayal.
- Terri, 18 years, abused by her father, and whose continuing determination to kill herself with creativity and clear-headedness have made me face, as a man, a sense of complicity and inaction for the effects of men's culture on girls' lives.

Keeping clear about these teachers of mine makes it possible to acknowledge to them their contribution to my politics, my life and my work with others. These are learnings that I can use the reflecting team structure to speak about and to acknowledge these people properly as the source. And keeping Debbie, Maria, Dave and Terri in mind stops me feeling alone in struggling, isolated in failure, or hopeless in the face of disappointment.

deconstructing expert knowledge

Knowing how to run our lives is not a basis for knowing how others should run theirs - this is to confuse our life with theirs - but developing expert-generalised knowledge from our own lives or theories about peoples' lives is increasingly popular. Questioning such knowledge can help people unpack and reveal the foundation, purposes, and legitimacy for such 'expertise'. These questions make expertise more personal and help prevent the disconnection of lives that seems to be such a factor in burnout.

Possible questions include:

- What effects do you intend your opinion to have?
- How do such effects fit within your ideas about how I should lead my life?
- Which personal experiences have helped you form these opinions?
- In which ways do your ideas and opinions support your location in the social or work systems?
- Who was the original author of these ideas?
- Who is advantaged and who disadvantaged by these ideas?
- Did those disadvantaged by this idea have opportunities to suggest alternative ideas?
- Which alternative ideas were considered and rejected?
- Which theories does this account privilege? Which theories are overlooked?
- How difficult would it be for someone disadvantaged by this idea to replace it with one that was more generous towards them?

conclusion

The practices described here are some of those I aspire to, they are work in progress. However, my interest in clinical work has increased and my interest in becoming a manager or early retirement decreased since beginning to take them up. I was possibly one of the few people pleased to hear that the retirement age in UK is proposed to rise from 65 to 67!

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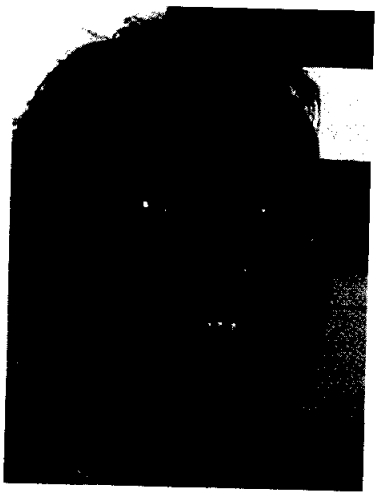

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