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The impact of NHS change processes on art therapists working in LD services
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ABSTRACT
The impact of working as art therapists in the NHS during protracted change processes, with people with learning disabilities (LD), was investigated in a qualitative heuristic doctoral study (Ashby, 2018), which considered concerns about emotional exhaustion and reduced efficacy, symptoms of burnout (Maslach, 1982), as a result of occupational stress. The researcher’s own data was examined, and 15 art therapists employed by NHS Trusts across England were interviewed. This article explores how the research was conducted, its findings related to LD services in the NHS and wider employment issues, and addresses how the findings are relevant to all art therapists. Most burnout studies are quantitative and consider workplace sources of occupational stress, but this qualitative research importantly revealed how crucial personal sources of support and stress were in terms of aiding or reducing clinicians’ capacities to cope. There was evidence of job satisfaction, resilience, and personal growth developed over years of practice, and high levels of stress resulted in symptoms of burnout in some participants, but recovery was shown to be possible.

Plain-language summary
Research into the impact of working as an art therapist in learning disability (LD) services in the NHS in England during long periods of change processes found sources of stress and of job satisfaction (Ashby, 2018). The doctoral research was qualitative, using heuristic methodology as the researcher had experience of the issues investigated, and 15 art therapists were interviewed.

This article discusses the relevant literature, the way the research was done, and findings of the research; it applies the knowledge gained to the situations many art therapists experience in their practice with different organisations and work environments. The impact on art therapists was investigated as both positive and negative aspects of their working lives were evident, and sources of job satisfaction and of occupational stress were experienced, including burnout symptoms of emotional exhaustion and reduced capacity to work, though not depersonalisation (Maslach, 1982).

Organisational sources of satisfaction and stress within NHS LD services were identified, and employment issues for art therapists became apparent in relation to job insecurity, within the depressed employment market.

This qualitative research found that personal sources of support or stress could result in art therapists being able or unable to manage coping with occupational stress if multiple sources of stress were present. Burnout symptoms of emotional exhaustion and a reduced capacity to manage their workload resulted from these situations for some participants, however, those affected were able to recover when they addressed the occupational stress that had become too much for them; no participants avoided contact with service users.

Introduction
Research into the impact on art therapists of working with people with learning disabilities within NHS LD services was undertaken in the context of a PhD, as a result of my own experience of occupational stress, and that of a valued arts therapist colleague who burnt out (Ashby, 2018). I found this experience disturbing, particularly as the human resources processes of the NHS Trust were disciplinary rather than supportive since burnout does not exist as a medical diagnosis in the UK.

My colleague had been highly committed, despite the fact that working with people who have severe LD and challenging behaviour was physically and emotionally demanding, and had a significant impact on the therapists’ and other workers’ thinking processes. He was rarely off sick and took his responsibilities seriously. However, after about six years of working in this environment my colleague began to be late coming to work, went off sick frequently, failed to complete written reports or let people know what was happening – in fact, his life seemed to completely unravel. He was unable to recognise what was happening to him, and I began to suspect burnout; I suggested he went to see his GP, and he was signed off sick, never to return to his post. The unravelling of
his capacity for work looked like a disciplinary process was called for, and this was the process that was followed since the department did not recognise burnout.

I was impacted by that situation and was concerned that it should not happen to others. I had undertaken quantitative research into art therapy work with people with severe LD and challenging behaviour, addressing working conditions and approaches, and to a limited extent the impact on the art therapist of the work (Ashby, 2004, 2011), and then decided to investigate burnout in art therapists in the context of a doctorate.

**Literature review**

As I investigated the literature, I discovered that art therapists researched and wrote about art therapy practice, but very little was written about the impact of the work on the art therapist. The literature addressed here concerns occupational stress and burnout in general terms and in art therapists, discusses how change processes in the NHS contribute to the stress experienced by staff and addresses employment issues for art therapists.

**Change in the NHS**

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 30 years due to changes in government policy with the benefits being only moderately realised (Jeffcoate, 2005; Klein, 2013; Oliver, 2005; Walshe, 2003).

Transforming Care, a policy introduced by the Department of Health (2012) in the wake of the Winterbourne scandal, and addressed by the Bubb Report (Transforming Care Steering Group, 2014) and NHS England (2015), aimed to reduce long-stay inpatient admissions for people with learning disabilities. Implementation took longer than expected due to a lack of adequate provision for appropriate care within the wider community experienced in some areas (Taylor, McKinnon, Thorpe, & Gillmerr, 2017; Washington, Bull, & Woodrow, 2019) and difficulties implementing LD policy (Broadhurst, 2017; Kerrigan & Hopper, 2017; Painter, Ingham, Trevithick, Hastings, & Roy, 2018). However, Transforming Care was positive for some people with LD (Turner, 2019), service providers (Clifford, Standen, & Jones, 2018), and length of inpatient stays has been reducing (Washington et al., 2019).

Studies into the impact of NHS mergers and restructuring processes were conducted by Goddard and Palmer (2010), Loretto, Platt, and Popham (2010), Macintosh, Beech, Mcqueen, and Reid (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 well-being and on Trust processes that needed to be integrated. The study by Loretto et al. (2010) included personal data in their analysis. 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 well-being among staff, rose during restructuring processes.

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.

The 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 the acquisition of neighbouring Trusts, and many were taken over, and these processes took place in the decade prior to the widespread restructuring experienced by the researcher and 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 well-being. Lack of communication and management support were consistently found to be problems, and staff anxiety rose particularly if their jobs were under threat.

The only study I found that included art therapists in its sample was a survey study into the perceptions of members of five multi-disciplinary integrated community teams (MDTs) for people with LD in England 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. Well-being 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, Horne, and Mitchell (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).

**Employment issues for art therapists**

Employment for art therapists is an ongoing matter of concern, particularly for those newly qualified, and those for whom job insecurity is an issue, and so national art therapy associations regularly conduct membership surveys, such as those conducted by the British Association of Art Therapists (BAAT, 2019). In 1982 pay structures in the NHS were established (Waller, 1991) and in 2004 these were revised, but not all art therapists were happy with the outcome (Usiskin, 2007). Concern about employment issues was raised by Kyriakidou and Gale (2012), who stated that searches for art therapy employment revealed nothing in that time period.

Working environments have been much discussed in the literature too, as the advent of deinstitutionalisation of people with disabilities reduced clinical space available for art therapists and affected their practice (Hall, 2001). Increasing difficulties with inappropriate working environments were discussed by Morrison and Anderton (2007), and in LD services were discussed in Ashby’s research (2004, 2011).

**Burnout**

Occupational stress affects people psychologically and physically, and many people experience minor aches and pains every day as a result of a sedentary lifestyle (Sedlacek, 1989). Stress can cause serious illness, such as heart conditions, autoimmune syndromes, and these can also be life-threatening (Axe, 2016; O’Bryan, 2016; Taylor & Cooper, 1989; Wentz & Nowosadzka, 2013). Accumulation of stress over prolonged periods can result in a gradual decline towards burnout (Schaufeli & Buunk, 1996).

Burnout has been extensively researched because of the impact on employment, and Maslach (1982) identified burnout as having three distinctive components. Emotional exhaustion, where work is experienced as emotionally draining and eventually people become exhausted, which reduces their personal efficacy, and depersonalisation, which results in workers avoiding contact with service users and having less concern for them. For further information see Ashby (2018).

**Occupational stress in art therapists**

Little research has been conducted into occupational stress in art therapists or burnout. Art therapy interventions for burnout or work-related stress were reviewed and discussed by Huet (2015), and she also addressed art therapists with experience of mental health services (Huet & Holttum, 2016); Tjasink and Soosaipillai (2019) recently added to this body of knowledge. Gam, Gabsook, and Youngsook (2016) and Orkibi (2016) conducted surveys with art therapists to measure burnout, and found that professional experience, age, membership of a professional association, good supervision, supervisor status, working in both private and public settings, a good salary, and good person-environment fit, correlated with high scores on artistic and social characteristics, were protective against burnout.

**Summary**

The review addressed change in the NHS, which shows that mergers and takeovers have been widespread within the NHS, and had a significant impact on staff stress; there has been much research into these issues. Employment issues for art therapists was addressed, and occupational stress and burnout were briefly explored, as was occupational stress in art therapists, of which little research has been conducted.

**Methodology**

Heuristic methodology, as developed by Moustakas (1990), was appropriate for this qualitative research, because it takes the researcher’s experience as its starting point, providing a means for a rigorous self-analytic investigation into the researcher’s experience, and then drawing on that experience to recruit participants. Before the research could proceed ethics had to be examined both by the university and by the NHS research process IRAS (Integrated Research Application System).

The first stage of my engagement with the heuristic methodology was an analysis of my self-search data, which was collected through an examination of my journal entries through a period of work with people with severe LD and challenging behaviour in a specialist NHS unit. The very stressful nature of the work, and the considerable negative impact on the staff, including the arts therapists (of which I was the art therapist...
in the unit) was very apparent from the data and formed an account of the background to the investigation. The impact particularly was felt in terms of emotions (such as anger, frustration and fear), tiredness and difficulties thinking, reflecting issues that the clients also experienced.

The next stage was to recruit participants, which had to be done via IRAS, and applications made to NHS Trusts to interview any art therapists who worked there with people with LD. This process was much more complicated than professional networking would have been, however, I recruited 15 art therapists who worked in NHS LD services via emails and telephone calls. I travelled to 11 sites across England to their workplaces to interview them (some of the participants worked in the same NHS Trusts). Participants were provided with full details of the research including the right to withdraw, signed consent for their data to be recorded and transcribed by myself, agreed pseudonyms, and agreed to review the transcripts, analysis of the data, and other iterations of the findings, and to allow publication of the data (Figures 1 and 2).

The data was anonymised, using pseudonyms chosen by the participants, and securely stored within an NHS facility. Interviews, after an initial introduction and signing of consent forms, took a free-flowing conversational style over 1 to 2 h, and the transcripts were constructed in the same format. The process of transcribing the recorded data enabled me to think about the data, and I used Thematic Analysis (Braun & Clarke, 2006; Vaismoradi, Turunen, & Bondas, 2013; West, 2013) to analyse it. My PhD supervisors were my auditors, and the participants also fed back about the data analysis and subsequent writing up. Reflexivity and transparency were very important to the process (Etherington, 2004; Reinharz, 1997). Insider and outsider processes were also present, as I was an insider being an art therapist, but an outsider not being a member of the participants’ team or workplace (Edwards, 2002; Fossey, Harvey, Mcdermott, & Davidson, 2002; Robson, 2002; Rooney, 2005).

The research findings

Of the themes that emerged from my analysis of the data, this paper addresses issues related to NHS employment: ongoing change in the NHS, work intensification, job insecurity, changes in working conditions, working environments, and NHS values. The data then addresses the participants’ commitment to the client group, employment, well-being and stress experienced by participants.

Ongoing change in the NHS

Widespread change as a result of mergers and takeovers, in which larger NHS Trusts took over smaller Trusts, was experienced by participants. 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.

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. 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. 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, who also experienced change fatigue.

Job insecurity over protracted periods of time caused considerable uncertainty and anxiety, 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? We get a lot of referrals every week, we’re a really busy team.

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’.

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. 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.

However, all the art therapists whose Trusts had been through recent restructuring did keep their jobs.

Work intensification

Workloads increased and intensified for the community-based art therapists and researcher, 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’. 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 …’.

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.

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

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

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.

One participant found that distances he had to travel had doubled. Physically it was tiring: ‘I can be quite agile … but it is quite tiring’ another said.

For five participants 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.

More time was spent in sedentary activity on computers, at desks and in cars, and working overtime increased. For four of us 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.

Although this participant used her overtime to improve her well-being, another who also worked overtime did not take it back and it ate into his personal life, as it did in two other’s situations.

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. Two art therapists were happy with their working conditions following restructuring and felt able to manage the pressures they were subject to. One worked part-time and did not have to hot-desk; the other had a balanced caseload and variety in his working week, and his team had retained their clinical rooms and offices.

Working environments

Difficulties were experienced with working environments. Acquiring appropriate space for art therapy work was an issue for eight participants and me. One participant acquired a budget for room hire when his dedicated room was no longer available, and developed a database of suitable rooms. Another art therapist 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 out one yet, that is an issue!

In inpatient settings, clinical space was difficult to arrange appropriately for three participants. One’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. Thus it was apparent that organisations did not understand what was needed for art therapy in terms of appropriate space; they also did not understand about the need for consistency, disabled access, appropriate materials and other aspects of the working environment.

Changing values

Participants’ 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’. 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’.

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 and ‘… a corrupt value’.

Three participants felt they had a voice within their organisation, but most felt that our voices were not heard within the organisations; when serious concerns about planned change were raised they were ‘knocked back’, 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’. Some participants also perceived that there was prejudice against the LD client group and that NHS staff working in that area were marginalised.

Commitment

All the art therapists were committed to work with people with learning disabilities, 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’.

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.

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 …’.

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.

**Employment**

The participants were highly committed to working as art therapists, ten of them having done so for over 15 years, usually within the same organisation, as I had, and their well-being 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.

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. The apparent lack of movement in the employment market had significant implications for the art therapists’ career prospects. One participant who had been qualified for three years found it hard to gain permanent employment, and another’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 alternative work because of the needs of their dependents:

Redundancy might be the only option for some art therapists, however, one participant had been made redundant and found that experience immensely distressing, and some years later was still feeling the impact. None of the participants were down-banded but one arts therapies 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. Two participants became lone practitioners when their colleagues left and their posts were lost or remained vacant, situations that had been replicated over the years in seven other NHS Trusts.

Four of the art therapists worked full-time in one job, and six worked part-time in one job. Of these, two 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 and took it.

Five participants worked in multiple roles, most of them full-time, and only one participant found this suited her, whereas the others experienced significant stress as a result:

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.

Working full or part-time in multiple jobs or roles had a significant negative impact on the well-being of the participants.

**Well-being**

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, and two participants investigated the employment market and found they could not easily move jobs.

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. 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.

**Stress in the participants**

Two participants did not feel stressed, and three were only minimally stressed. These therapists had made significant adoptions to the way they practiced, had come through restructuring and were coping with the consequences, felt supported at home and work, and seemed quite resilient. Four of the participants rated their stress at six out of ten, as their NHS Trusts were still going through highly stressful change processes, but also benefitted from working part-time which assisted them to mitigate their stress. However, three were also experiencing personal stresses, and one had two jobs, hence their stress was higher but still within manageable limits.

Six of the art therapists were still going through restructuring processes in their Trusts and were struggling as a result. Only two worked part-time, the rest worked full-time in multiple jobs or roles, and this fact compromised their coping strategies. They also had personal sources of stress they were managing, and so were coping with combinations of stress and less support because of the stress at home; several of these participants were also not feeling supported at work either. Thus, these six were at risk of burnout but did not entirely succumb to the syndrome. The fact that three, possibly more, were experiencing emotional exhaustion, and their stress was affecting their capacity to work to the best of their ability, meant that it was imperative they took action to stop burnout in its tracks, which they did.

Recovery post-illness and emotional exhaustion was possible, and the younger participants were likely to be able to bounce back much easier than those who had been practicing for 20 years or more. Participants who were older were able to recover but subsequently felt more fragile and took greater care of their health and well-being than they previously realised was necessary.

**Discussion**

The findings have shown that I and the participants experienced significant changes in our NHS Trusts, which gave rise to high-stress levels and changed our working conditions and practices, as experienced by staff in the research discussed earlier (such as Goddard & Palmer, 2010; Macintosh et al., 2007). Community-based participants experienced the most change and increase in their working conditions, but restructuring impacted all staff in the NHS Trusts. Work intensification and change fatigue was experienced, and work became more physically and psychologically demanding with increased driving, workload, admin, and waiting lists, and struggles with accessing clinical space. Orkibi (2016) noted that bad person-environment fit correlated with higher burnout scores and that those with less experience were more likely to burnout. Both these were shown to be true for my participants, although personal sources of stress were not included in Orkibi’s research.

Values changed in the NHS Trusts, and the focus of management became more orientated towards financial concerns than patient concerns; some of the restructuring processes had felt predatory, and participants had found their colleagues became less supportive when they too were highly stressed. Doing more with fewer resources has become an attitude that is now prevalent in NHS Trusts, as workload and estate resources became stretched during mergers that took time to settle into workable patterns, as the literature had identified.

Participants were highly committed to their jobs, their clients and the learning disabilities client group, and tended to stay in their jobs for many years, due to lack of employment opportunities elsewhere. Job insecurity raised stress levels, though all participants did keep their jobs; those who felt it might be time to move on found that they could not due to the employment situation and their family commitments. Thus, job insecurity is of greater significance for art therapists than for members of professions, such as nursing and occupational therapy, where there are not enough practitioners to fill posts.

Support at work was generally good, with managers, supervisors and colleagues providing support, except in times of exceptionally high stress. This research, however, showed that although most participants found their family situations manageable and supportive, there were some whose situations had unravelled, and for whom personal stresses tipped the balance between coping and experiencing burnout symptoms of emotional exhaustion, and at times reduced efficacy at work. Those who had less experience tended to lack awareness of their need for adequate self-care strategies and stress management interventions, and were feeling highly stressed but had not yet reached burnout, however they were in danger of doing so. However, their participation in the research suggested they were aware to a point.

Working part-time in one job was helpful in managing highly stressful situations, but working full-time in multiple roles and jobs was generally unhelpful for well-being; only one participant, who was due to go on maternity leave shortly, found it stimulating. The rest of the participants found it added considerably to their stress.

Some participants made considerable efforts and adaptations to improve their well-being. One completely changed his working practice, and two moved roles when the opportunity arose to improve their well-being. Most of the ‘less stressed’ and the ‘stressed
but managing’ groups of participants employed good self-care strategies mindfully, and had sufficient support.

Two participants were able to recover from emotional exhaustion by employing holistic self-care strategies and accessing stress management interventions (through finding a therapist); this is a positive finding, as they showed that recovery from burnout symptoms, if they have not become all-consuming, is possible. No participants experienced the depersonalisation burnout symptom, but some had experience of reduced personal accomplishment when they were feeling exhausted.

Implications for practice

It was apparent that well-considered self-care strategies were necessary to maintain well-being, and some of the participants’ approaches were highly beneficial and enabled them to become resilient and to cope with high stress levels. Stress management strategies were shown to be necessary to provide further support when the self-care strategy is found to be insufficient for the situation.

The prevalence of continuing ongoing change in the NHS, and other institutions such as education and social care, make it apparent that art therapists practising in all situations need to be mindful of their stress, and make efforts to keep their stress levels under control. Art therapists, as all healthcare practitioners do, have an ethical responsibility to their clients to maintain fitness to practice, and therefore have to take active steps to maintain their well-being.

The research also showed how much importance art therapists placed on a good relationship with their clinical supervisor (and with their manager and colleagues) to assist them in maintaining their well-being, and this is a subject not discussed in the supervision literature.

It is encouraging that emotional exhaustion can be recovered from; however, it seemed that practitioners who experienced this burnout symptom along with significant ill-health were less robust afterwards, although more self-aware.

Limitations to the research

This research would have benefited from having mixed methods, such as the use of the MBI (Maslach Burnout Inventory, Maslach, Jackson, Leiter, Schaufeli, & Schwab, 1986) to measure the participants’ stress. I also considered doing a workforce stress survey but was unable to include this in the current research.

Conclusion

Restructuring and re-organisation of NHS Trusts were shown to be highly stressful to participants in this research, and job insecurity to be a significant factor in the stress experienced by art therapists during these processes. Changes to working conditions and environments increased workloads, and physical and psychological effort required, and these processes are ongoing in the NHS.

High levels of commitment to their work with people who have learning disabilities, and capacity to adapt were demonstrated by the participant art therapists, who experienced job satisfaction when good work and a supportive environment were possible. Not all the participants’ managers and colleagues were supportive, although supervisors generally were, and many working environments post-restructuring increased stress and effort.

Self-care strategies were shown to be helpful in maintaining well-being during times of change and insecurity, providing personal situations remained supportive. However, when these were adversely affected both physical and psychological well-being were affected, and emotional exhaustion was experienced by some participants. Recovery was shown to be possible providing well-considered self-care strategies and stress management interventions were adequately addressed. Personal stress was shown to reduce participants’ capacity for well-being and put them at greater risk of burnout, an issue raised in the UK guidelines for art therapists working with people with learning disabilities (Hackett, Ashby, Parker, Goody, & Power, 2017).

These findings are useful for the general population of art therapists, many of whom work with stressful client groups, and within organisations where they experience stress. Self-care needs to be adequately addressed to protect the workforce from emotional exhaustion, which can be the result of exposure to stress from the client work, and from burnout, which is a devastating syndrome to fall prey to as a result of work-related stress.

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Disclosure statement

No potential conflict of interest was reported by the author.

Notes on contributor

Dr Elizabeth Ashby is an art therapist who has worked for over 20 years in the NHS with older people with mental health problems, and with people who have learning disabilities. She is passionate about her work in the NHS, and has provided many trainee placements. Further to her art therapy training she studied for a Masters in Research, and then for a PhD. She is also a registered private practitioner and supervisor. She is currently a member of BAAT council, an Associate Editor of IJAT and Newsbriefing, and joint co-ordinator of ATLD SIG.

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