6

Psychological and Emotional Support in the Workplace: Can It Make a Difference for the Longer Term?

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Introduction

All through my career I have been supervising and supporting people in the workplace. In the 1970s and 1980s, while working in the old Victorian mental health Asylums, I became aware of the stress responses described by some colleagues (Don Bannister 1976, personal communication) that were not only obvious in the patients but also in the staff—from porters, to nurses, to psychiatrists, psychologists and social workers, but also for the secretaries in those institutions who typed the letters describing the conditions of individual patients. And then of course, there were the gardeners who cared not only for the plants and gardens but also for the patients who became involved in the gardening. All of the above working people could become distressed by what they saw, heard and experienced with and for the patients as well as being under stress themselves from overworking. By realising that work can be stressful in

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so many ways and at any time—and sometimes over long periods—and can lead to poor health for those working in psychologically unhealthy environments (both physically and emotionally), I understood that the workforce needed to be supported emotionally. At that time, much more than now in 2019, acknowledging and speaking about stress, distress, let alone depression or work-related burnout, would have been and was a very hard step to take. It would have been labelled as being weak and not fit for the challenges of work.

Of course the 1st and 2nd World Wars in Europe and across the world, made it possible to begin to think that being involved in the most atrocious situations in war had consequences for the soldiers and could affect their psychological health in fundamental ways. Pat Barker's fiction writing (1966) describes some of the work that was undertaken to help 'shell shocked' soldiers (Bion 1997) which is now much more understood in terms of trauma and Post Traumatic Stress Disorder (PTSD). Later research undertaken by Figley (1995), Figley and Nash (2007) gave an insight into how the understanding of the kind of stress experienced in combat situations could be transferred into areas of other professional stress. Slowly, over the years, it has become possible to recognise that stress at work can have the same consequences and thus needs our detailed attention.

Throughout the years of working as a clinical psychologist in the UK National Health Service (NHS), I have divided my work between adults, families and children in the area of child abuse. In 2001, my colleagues in Paediatrics and myself set up an innovative service to support staff, particularly Paediatricians, in their work in the area of child abuse.

I had begun to think about supporting those working in the field of Paediatrics where doctors and other staff were seeing children and their families where child abuse had occurred. I knew that all those working in this area, including myself, had been affected in many ways. Burnout was a real threat. However, at that time little was written about the matter. The most severe outcomes, like 'burnout' had been written about by Freudenberg (1974) and later Masson (1990) but back then and in many fields of work today, 'risk', as in risk to the Organisation, was and still is the main topic of concern in most Organisations. Boland (2006) wrote an important account of what can happen to professionals working in

the area of child abuse, particularly if the Organisations they work in are as disorganised as some of the families. Caring for the workforce is only now becoming something that people recognise and acknowledge with relevant action. The recent BMA report (2018) that discusses how to 'care for the mental health of the medical workforce' is one such example. What we did know more about was 'trauma' and how that impacted on the person even from a very young age (Crittenden 2008). The attachment literature, research and practice at the time recognised the neurological impact of stress on infants and children, but here, I want to return to the work with staff in the UK NHS.

There is no doubt in my mind that it is difficult to build a culture in which it is acceptable for doctors, or any other professions, at whatever level in their career, to seek and/or accept emotional/psychological support. My curiosity about what medical staff and others feel, or are taught, about what it means to them when they seek support, has been heightened during the time I have worked in this field. My thinking has revolved around how to help staff not to feel somehow that they are weak or inadequate because of seeking support.

Today, in 2019, we have available a considerable literature concerned with stress in the workplace, such as Bennett et al. (2005), Maslach and Leiter (2008), Figley (2008), Hanks and Vetere (2016), BMA project (2018) and Gorvett (2019). How it affects and impacts people, what they might do about it, where it occurs, such as in financial services, government, the NHS, Universities and Education, the Police Services, and in large global companies as well as in the more local and smaller businesses is now much better understood than in the NHS, even though by definition the NHS is well aware of ill health. Stress is a major factor in NHS employees and staff not being as well as they should be is sadly a common experience (Obholzer and Roberts 1994; Lyth 1988). In April 2019, the Health Secretary for the UK, Matt Hancock, pointed out (article in *The Guardian*, 25 April 2019, page 13 by Jessica Elgot) that the NHS needed to adopt 'a more compassionate culture towards staff' and said 'that staff, amongst other issues, had to work inflexible shift and rota systems despite ill health, family tragedy or events, etc. and all because the management was unwilling to design staff rotas at a rate which encompassed the fact that it was human beings, with all their

complexities, that they were dealing with'. In some way this seems such a small issue but it makes visible the intransigence that can develop in large Organisations. Losing touch with compassion and nurturing and instead creating a system of blaming, controlling and even bullying and harassment is detrimental to the individuals and ultimately to the Organisation as a whole (Reeves 2019).

Another reason why the workforce can be put under severe stress is that there are constant changes in the Organisation, such as changes in regulations and guidelines which are frequently re-edited and re-worked. In turn it can be observed that the workforce mirrors the unpredictable and often unresponsive senior layer of management as well as re-creating a blaming culture. Groups within the workforce (in the environments that I describe here) and departments can become dysfunctional and act either individually and/or collectively in many ways like the abusive families the staff work with. In my experience, this is a very important point to recognise and take action around. It is also well worth remembering here that child abuse work is unpopular, as it includes some serious and unavoidable risks for the workforce. There are numerous examples of 'medical, social work and other professional victims', and often the guidance and procedure of clinical practice is unclear. Attacks on this work and those involved in protecting children are a world-wide phenomenon.

How It Started in Leeds

With the support of some broadminded colleagues in the medical profession, who had the foresight to see that the stress of child abuse was playing havoc with staff wellbeing, we began to think about a service that might support doctors and staff when they worked in the area of child abuse. (*I would like to point out here that I use the term 'child abuse' deliberately because the currently preferred language to my mind hides the atrocious behaviour of some people towards some children when child abuse occurs. The more recent terms like 'child protection' and 'safeguarding' do not remind us of the enormity of the abuse experienced by children, rather they hide its enormity.*)

As I write the above, it is worth remembering that even in the medical professions the idea of needing psychological support to do their work was not looked upon kindly, but more as a failure in the person/staff to be strong. After all, these were the people who were supposed to be the strong ones! Also the idea of psychological support (even in the broadest sense) was thought to be what doctors offered in order to help others i.e. the patients, but not the clinicians.

So in 2002 we started the psychological support service in earnest and offered staff an opportunity to talk individually or sometimes in groups. I developed a leaflet to describe the service. The funding was for 1 session (3.5 hours) per week and I was employed by the NHS Trust. The time allocated was not much and I have to acknowledge that I often gave more time as the years passed and people became more trusting of me and the service.

Staff could make appointments to talk or I made sure if there was space to let staff know that they could come. The appointments lasted for approximately 1 hour. I also gave presentations about stress and related topics to the department. I made very clear when I was in the department and available.

What Is Psychological Support?

We used the word 'support' deliberately because we did not want to give the impression that this service provided therapy. A leaflet spelt this out and stated that: 'The support centres around any topic of work related to child protection and how this is impacting on the individual emotionally, causing anxiety, stress and uncertainty. Both work and private issues can be discussed'.

The aim of providing a service to this group of professional people was to make available psychological and emotional support in order to prevent professional and emotional harm, and to enhance the service received by children and families. The support centred mainly around topics related to work (work with children, their families, with colleagues, with management, other professionals, the Courts and so on), but very importantly I also included the notion that work in general,

but child abuse work in particular, impacts on our private lives. Equally private lives impact on our work. And so all of these themes were points of discussion, though entirely the choice of the professional. An integration of systemic as well as psychodynamic ways of thinking became paramount.

The approach to 'support' was based on a systemic framework (Dallos and Draper 2015) to understand how people function in professional systems and to think of acceptable ways for the professionals to consider alternatives. This is combined with a psychodynamic understanding of how people adapt to stress and how each individual reacts differently under circumstances where they witness the consequences of abuse or are experiencing aggression towards themselves. The boundaries between support counselling and therapy were clear in my mind and I was careful to pay attention to these distinctions. Though it must be said it proved to be easier to recognise this when we strayed into what might have seemed clinical supervision. While I advocated strongly that clinical supervision was essential, it had to be done separately and by the appropriate people.

It might not be difficult to imagine that it took some time for the support service to get under way. Although in principal people were much in favour that such a service should exist, making use of it and booking an appointment with me, took some time. The thought of speaking with someone about personal, and sometimes distressing issues was harder than it first appeared. Over time, with the experience of using the service, or seeing colleagues using the service, the hesitancy eased and the service and I were perceived as being helpful and even necessary.

During this time, it also became obvious that secretaries typing distressing material in letters and reports (whether to do with child abuse, complex severe illness or the incidence of a patient dying) was immensely upsetting and often led to the person who has typed the report or letter not being able to let go of the material, to be thinking about it for a long time, and to possibly not sleeping at night, and so on. We found that the almost 'passive' role of the secretary typing the events around the abuse was at times intensely painful and stressful to that person. The feeling of being helpless to make things better for the child was often unbearable in such situations. Support was welcomed and taken up.

An example: *A person discussed the death of a very young infant who had allegedly died because of abuse. The doctor was very distressed and as we talked about this tragic case it became clear that this person had a baby of the same age. The images and thoughts were so strong and the doctor tried to find a way of being able to go home and not discuss the happening but to explain to the spouse why this had been such a distressing day.*

Professionals need care too. Our heart goes out to those children who have suffered abuse. We feel the distress that others feel. When looking after children (and others in distress) we cannot escape being reminded of our own vulnerability. By reaching out to those children, we are also reaching out to ourselves and those we care about.

It was no surprise to find that the extended discussions which took place over many years were intensive and very wide ranging. These discussions ranged from case material, to working together with other professionals, to organisational demands and stresses, personal demands, different opinions between professionals and the Organisations they worked in. Also difficulties in the wider system were discussed, including what happened when staff were in Court presenting evidence, struggling to forge links with other disciplines, attending case conferences, and how to respond to media stories that were clearly false, and so on. The denial in the system, and in the world at large, that child abuse and particularly sexual abuse existed, was high. Those who believed the stories of the children and young people were often criticised for doing so. It was not until the Cleveland Report of Inquiry into Child Abuse in 1987 that Dame Butler-Sloss made an unequivocal judgement; 'that sexual abuse occurs in children of all ages, including the very young, to boys as well as girls, in all classes of society and frequently within the privacy of the family' (Hobbs et al. 1999). Personal attacks on those attempting to protect children were not uncommon. Some of this still exists in 2019.

These discussions were often intense and tense and showed how work and looking after patients over the years had often gone far beyond what one would have expected. The Organisation, management and staff in other departments were often totally unaware of what these nurses, doctors, therapists, secretaries, receptionists and so on, had to deal with on a daily basis. As a clinical psychologist myself it was clear that I could not take on the role of clinical supervisor for the paediatricians, or other

associated professionals, but what I hoped to add to their practice was an understanding of the psychological issues surrounding their cases and the longer term psychological issues which impacted on the paediatricians themselves.

I did throughout my time with this work have supervision myself. The supervisor and I agreed on the confidentiality issues for this relatively small and identifiable group. Names were not mentioned and the group knew who the supervisor was. The supervisor did not know any of the people in the department and worked in a place far away.

Do Professionals Have a Duty to Look After Themselves?

By 2006 I was formulating the idea that professionals had a duty to look after themselves and I began to use this concept as a title in presentations at conferences and in teaching. In many professions the notion that looking after oneself is important had not been addressed specifically, either with theory or research. In my work with these professionals I was very careful not to make it sound as if they were to blame when they became stressed, tired and exhausted. I was strongly reminded by the practices in the NHS (no doubt elsewhere as well) that when vaccinations against influenza were introduced a culture of blaming grew. Because, if a member of staff became ill with influenza and had not been vaccinated they were blamed for having the influenza. As if somehow, vaccination was always a 100% protection.

I did not wish to imply that anyone suffering from stress and/or worse—burnout—could have prevented becoming ill. It is more that people in general could be made aware that there are ways of recognising that limits of stress have been reached and what steps can be taken prevent the worst outcomes. The practice of mindfulness as a general stress relief is a good example, however there has been recent research by Samra (2012) that workers who went on to develop burnout had actually better psychological health than the comparison group earlier in the study. Which suggested that those people who had training in the recognition of stressful events and the practice of mindfulness were

more likely to suffer from burnout than those that did not have that preventative knowledge. But why so? Could it be that mindfulness practice emphasises the role and resilience of the individual in the context of greater stress awareness, rather than also emphasising the clear importance of social support and community action to combat the effects of prolonged exposure to stress at work. When the authors looked specifically at burnout in professionals in Medicine they found that 'A large systematic review showed that both organisational and individual interventions are effective at reducing burnout. However the interventions need to be tailored and not only rely on teaching people skills like Mindfulness. Other interventions needed to be put in place at the same time'.

I observed that staff did take on board that the emotional support in individual and long term group meetings was a useful adjunct to self care and that it was worth making use of these sessions. I also noticed that there was a greater awareness about the importance of looking after each other. It was not that some of this had not happened before, but the quality of the care changed in the context of long term participation in the support of individual and group sessions. Conversations with one another about such matters as overworking became more frequent and demanded a response: 'I recognised you were here after I left for home at 7:30 pm, so when did you leave? Have you had your lunch? Have you been able to catch up with your patient letters?' As these kinds of conversations became more frequent amongst the staff they contributed to a greater sense of cohesiveness and emotional safety. Now this did not mean that there were no 'ups and downs'. It seems inevitable that an environment which deals with abuse and violence, tragedy and stress at the highest level can also produce strife, distrust and blame. It is when there is someone who can recognise this state of affairs, spell it out and work with the staff on resolution and giving support that things can get better again. And this takes time, commitment and patience over the longer term. It may be useful to point out here that I was there for 18 years but so were many of the staff and it was the relationship, and trust that developed during this time that was an important factor in the work.

It is my long held opinion and experience that it is supportive when the workforce is helped to think of the consequences of their actions,

to recognise when they have been overworking, when they have been harassed or bullied by others, and how this makes them feel stressed and possibly ill. All staff members need to know where to go to get consistent and predictable help. A recent anonymous survey about 'stress in the workplace' showed that 90% of the participants did not tell anyone that they felt so stressed they could not go to work. They gave different reasons for their absence at work. (www.bmj.com). They felt that a terrible stigma was associated with mental health—and that included stress.

When people have been fatigued, stressed and unable to work, they need a period of time for recovery. It is important to acknowledge this in the workplace. It often takes longer to recover than we all think. In this fast paced world it can mean longer than employers will allow before becoming impatient and implying that we are weak, lazy, and not pulling our weight, and so on. Thus, making sensible decisions is sometimes not easy under such pressure. But there will be more pressure if there is a recurrence of the stress and things can escalate possibly into denial of the situation and further ill health. These topics featured in our individual and group-based consultations. As trust grew between group members and myself it became more and more possible to openly and straight forwardly address the impact of the work, and to look for shared solutions. Thus, what did we learn to look out for—for ourselves and for each other? To become aware of long hours at work. To ask, can you say 'no' to the demands which mean you will work longer hours? Who will help you to say 'no'? To encourage everyone to take a break during the day, and to eat and drink sensibly at work and at home. My colleagues groan when I say, during the working week '….and forego the wine when you get home and are feeling stressed'. To pay attention to your family relationships and your social life. To meet with friends, to learn new skills, to take your holidays and all your annual leave, and so on.

There is of course a crucial and pivotal role for the Organisation too. How can we be helped to function energetically, positively and successfully in our work? Is it possible, especially if we do not have a caring, thoughtful, and honest system of appraisal and support operating in the workplace? In a recent editorial about burnout (Samra 2012) the author stated that: 'Medical workloads need to be reconfigured or

redesigned in line with human cognitive, emotional and physical limitations with accompanying Organisation-wide training and management support. Active participation from the professional workforce will be key to achieving success in the development of healthier and safer medical workplaces'. Professionals have a duty to themselves and to others to take care that they do not become ill because of stress. This is not always avoidable, especially when the Organisation does not have a culture of looking after their workforce. A paper by Hutchinson (2019) discusses the role Organisations have and asks whether the Organisations have a duty to keep their employees safe, rather than the employee having to take those steps alone.. She points to the misrepresentation of aspects like safety and care and says; '…safety measures can become rigidly applied and have the unintended consequence of demotivating and disengaging people, as they signal a lack of trust and reduce autonomy'.

Trust and Resilience Operating at Work

The topic of trust has been an important one throughout the 18 years I have worked with the staff group. A definition of 'trust' looks so simple and straight forward. The dictionary says: 'reliance on the integrity, justice, etc. of a person, or on some quality or attribute of a thing' (ref the dictionary). Attachment theory defines trust as the perception of responsiveness and accessibility in the other. However, we live in a world of 'Fake News' and in a digital age which regards confidentiality with little respect. Many things we do on the computer belong to Google or Facebook or some other social media. But therapy, support, counselling and mentoring are, or have been, in essence confidential unless the patient/client gave consent to share what they have talked about. There are very few exceptions to this.

I experienced the initial hesitant approaches by the staff while keeping the above firmly in mind. We would talk about confidentiality, what the exceptions were, and when we had to think of passing information on to a line manager or clinical supervisor. I made it very clear that, in the first place, I would encourage the person to discuss the issue we both thought needed to be discussed elsewhere. This may have concerned an

illness. I would ask the staff member to tell the line manager or supervisor to let me know that this had been done and broadly how the topic was covered. Otherwise our conversations remained confidential. I presumed staff checked out whether I was doing what I had said, and that they talked amongst themselves and checked out whether others had the experience of being able to trust me. The above is crucial in establishing a good, trustworthy relationships in therapy in general but becomes particularly important when working with individuals who are colleagues and work closely together in a department dealing with very sensitive matters on a daily basis.

Establishing a working relationship in therapy takes time and patience, particularly when it comes to working in the area of child abuse (Hanks and Stratton 2007). I have been concerned for a long time that the guidelines for short term therapy did not take into consideration how long it takes to establish a trusting therapeutic relationship. Three or 6 sessions during which complex problems have to be worked through are simply not enough in my experience, and in this particular working context. Thus we agreed that staff could make times to talk, and often book an appointment in advance. If we both felt that one or two meetings helped to get clarity about a difficulty, then this was fine. Meetings would generally last one hour. If we felt it needed more time we would agree further meetings. We had this flexibility. It was my role to continually monitor and negotiate this with management staff. It might be useful to mention Casement (1985, 2018) here who has encouraged me to continue over this 18 year period to see staff again and again with different difficulties but recognising that a thread might be linking specific feelings and behaviours and learn from these.

Over the years, we also agreed to meet in groups, sometimes with the whole department and more often in specialised, clinic-based groupings. Here we concentrated more on the clinical experiences staff had and how to resolve difficult matters, both clinical and administrative. In the group meetings we agreed not to talk about personal matters as such, but we did often explore what emotional feelings and thoughts we had relating to case material, to the group working together and the impact of outside influences. These included how people in administrative, or line management roles tried to make changes to the group. For example, how

administrative staff tried to influence who worked in the specialist clinics, and what patient groups should be seen in the clinics. The issue concentrated on numbers and costs rather than on quality and appropriateness of staff and clients. These decisions might be made without including the group member's experiences and expertise on the matter. Here again trust became a core issue. On reflection, I realise as I am writing this that we often did not overtly speak of trust, but I always knew that it was an issue.

In this context it is essential to think about resilience and what it means for clients and staff working in areas like child abuse. There has been an explosion of papers and books on the subject and I will not go into details of the matter. However, there are a few things I would like to highlight. Resilience is not some thing we either have or do not have. What contributes to becoming resilient includes learning about it, thinking about it and considering and recognising the beliefs we hold and how we attribute cause and effect. The definition, coming originally from engineering, which states that resilience depends on 'springing back into shape or position after being stretched, bent or compressed; recovering strength after a trauma or stress' seems to describe the human condition equally well. What needs to be remembered is that everyone is different and does it differently. Being resilient does not mean that people do not feel distressed, upset, suffer from stress or from trauma. Painful emotions and sadness are a common feature in people who have become resilient. And yet—Resilience is ordinary—not extraordinary.

A warning when thinking about resilience is to remember that resilience to stress is not the same as resistance to stress. Resistance implies that stress can be carried, come what may, and that there is no consequence of stress, that it does not matter. Taking on ever more, working more and more hours, enduring painful relationships without respite is no solution.

Support and supervision for adults, support and advocacy for children, having human beings around who are kind, caring and understanding are the building blocks for developing resilience and to our wellbeing (Colette and Ungar 2020, in press) stress, resilience is an outcome of relationships and context, not an internal quality of the individual.

Conclusion

There is no doubt that the psychological support over a long time established in the department provided a stabilising framework which enabled staff to talk about their difficulties, stresses, workloads, private lives and thoughts as well as organisational failings. Having been able to see the same people over this long period has been important and contributed to preventing burnout.

The process I have described started at a time when there was little appreciation of the potential value of providing psychological support to staff, not because they were showing symptoms of distress but because of a recognition that their work situation put them at risk. The structure we created, and refined over the years, has proven of great value to the team I was working in. Because it was conducted over a long period it was able to connect well to the growing awareness of the damaging effects on staff of unreasonable work situations and the consequent costs to the Organisation. The progressive understanding of the causes and consequences of burnout is relevant here. Another current connection is to the increasing sophistication of concepts of resilience and relational interdependence.

I hope this description of the development of the work over nearly 20 years will encourage others to create similar provision for staff in stressful work, and that they will be able to draw on the recent advances to improve on what we have achieved so far.

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