

Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical  
Psychology, May 2014

**Doctoral Thesis:**  
**Compassion and Burnout in Community Mental Health Work**

Rachel Wass (nee Watts)

Doctorate in Clinical Psychology

Division of Health Research

Lancaster University

## Word Counts

	<b>Main Text</b>	<b>Appendices (including title page, tables, figures and references)</b>	<b>Total</b>
Thesis abstract	205		205
Literature Review	7983	7810	15793
Research paper	7694	7863	15557
Critical Review	3976	670	4646
Ethics Section	2283	2490	4773
<b>Total</b>	<b>22141</b>	<b>18833</b>	<b>40974</b>

## **Abstract**

This doctoral thesis has three main sections: a systematic literature review, an empirical research paper and a critical appraisal. The literature review considers the factors associated with burnout in community mental health staff. Having synthesised the results of 28 papers, eight domains were identified that were associated with burnout. These included socio-demographics, work demographics, job stress and demand, support and supervision, individual characteristics, team context, client characteristics and role perception. Poor methodological rigour restricts the conclusions drawn from the reviewed papers, however a number of organisational factors were found to be of importance. The empirical paper considers the process behind the loss and maintenance of compassion in community mental health staff. Having interviewed 11 participants and utilised a grounded theory informed methodology, four core categories were identified; adopting a compassionate stance towards others, the uphill struggle, accessing a reflective space and working within a threatening system. The findings of this paper highlight the importance of reflective practice for mental health professionals and the influence of wider systemic factors. Lastly, the critical appraisal offers an extension of the study findings and reflections about conducting research in the field of compassion, as well as considering a number of decisions that were made with regard to the project.

## **Declaration**

This thesis records work undertaken for the Doctorate in Clinical Psychology at the Division of Health Research at Lancaster University from August 2013 to May 2014.

The work presented here is the author's own, except where due reference is made.

The work has not been submitted for the award of a higher degree elsewhere

Name: Rachel Wass (nee Watts)

Signature:

Date:



## **Acknowledgements**

Firstly, I would like to thank the participants for agreeing to discuss their experiences with me and in taking time out of what is often a very busy day. I would like to thank both my supervisors, Zoe Rivers and Fiona Eccles for their continued support and for their many words of advice and encouragement. Next, to the fabulous bunch of people that make up the 2011 cohort; you really are an inspiration to me and I feel incredibly blessed to have experienced clinical training with you (especially the 'motivational pictures' that kept cropping up!). To all my family and friends, who have not only supported me through this entire process, but have given me much enjoyment when I needed time away the thesis. Last, but certainly not least, to my wonderful husband who has been the most incredible person throughout this whole experience. Benj, the faith and confidence you have in me never ceases to amaze me and your words of love, encouragement and support have kept me going these past three years, thank you.

## Contents

### Section One: Literature Review

Title Page		1-1
Abstract		1-2
Introduction		1-3
Method		1-7
Results		1-9
Discussion		1-24
Conclusion		1-29
References		1-31
Figure 1	Flowchart of the selection process	1-41
Appendices		
Appendix 1- A	Author guidelines for target journal	1-42
Appendix 1- B	STROBE Statement	1-45
Appendix 1- C	Quality Assessment Criteria	1-48
Appendix 1-D	Description of the studies included	1-49

### Section Two: Research Paper

Title Page		2-1
Abstract		2-2
Introduction		2-3
Method		2-7
Results		2-11
Discussion		2-23
Conclusion		2-30

References		2-31
Figure 1	Diagrammatic representation of findings	2-41
Appendices		
Appendix 2- A	Author guidelines for target journal	2-42
Appendix 2- B	Participant Demographic Information	2-45
Appendix 2- C	Example Transcript Excerpt and Coding	2-46
Appendix 2-D	Categories and Sub-Categories	2-55
Appendix 2-E	Example of a Memo	2-57

### **Section Three: Critical Review**

Title Page		3-1
Introduction		3-2
Finding the right terminology		3-2
Extending the study findings		3-6
Reflecting on the presence of compassion		3-10
Conclusion		3-15
References		3-16

### **Section Four: Ethics Documents**

Title Page		4-1
Ethics Proposal		4-2
References		4-7
Faculty of Health & Medicine Research Ethics Committee application		4-9
Research and Development Department application		4-15
Appendices		

Appendix 4- A	Sponsor Letter	4-43
Appendix 4- B	University Ethics Approval Letter	4-44
Appendix 4- C	R & D Approval Letter	4-45
Appendix 4- D	Participant Information Sheet	4-47
Appendix 4- E	Consent Form	4-51
Appendix 4- F	Demographic Information Sheet	4-52
Appendix 4- G	Interview Schedule	4-53

**Section One: Literature Review**

The factors associated with burnout in community mental health staff.

**Word Count:** 7974

Rachel Wass (nee Watts)

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

**All correspondence should be sent to:**

Rachel Wass (nee Watts)

Doctorate in Clinical Psychology

Furness College

Lancaster University

Lancaster

LA1 4YT

[r.watts@lancaster.ac.uk](mailto:r.watts@lancaster.ac.uk)

Prepared for submission to: The Journal of Mental Health

**Abstract**

**Background:** Mental health professionals working in the community have high levels of burnout, with some suggesting levels of emotional exhaustion and depersonalisation are greater than staff working within inpatient services.

**Aims:** To synthesise and evaluate the factors that may influence levels of emotional exhaustion, depersonalisation and personal accomplishment in community mental health professionals.

**Method:** A systematic literature search was carried out using five electronic databases to identify relevant literature.

**Results:** 28 papers met the inclusion criteria for this review. The results of the reviewed papers illustrated eight domains pertaining to staff burnout, including socio-demographics, work demographics, job stress and demand, support and supervision, individual characteristics, team context, client characteristics and role perception.

**Conclusions:** These factors are considered in light of current literature and models of burnout. Clinical implications and directions for future research are also discussed.

**Keywords:** Mental Health, Staff, Burnout.

### **Introduction**

Working within mental health services can be highly stressful for staff (Ohaeri, 2003; Schulz et al., 1997). There is evidence to suggest this is greater than in other public sector workers due to the additional sources of pressure (Hannigan, Edwards, Coyle, Fothergill & Burnard, 2000). These include both the practical and emotional demands of caring for clients with complex needs, while simultaneously coping with the demands of a challenging organisational environment (Sherring & Knight, 2009). The last 10-15 years has seen a radical change in mental health services internationally with a move from inpatient care to a focus on community based services (Sherring & Knight, 2009; Weller, 1993). In the National Health Service (NHS), these rapid organisational changes have come with a significant reduction in service provision, such as fewer inpatient beds and a reduced work force (Sainsbury Centre for Mental Health, 2001). Consequently there has been a significant rise in the pressures faced by staff, increasing the risk of reduced quality of life and professional burnout (Acker, 2010; Rossie et al., 2012).

While several different definitions of burnout exist (e.g. Leiter & Schaufeli, 1996; Perlman & Hartman as cited in Schaufeli, Enzmann, & Girault, 1993), Maslach's (1982) is the most commonly used. Maslach (1982) defines burnout as a multifaceted concept characterised by high levels of emotional exhaustion (EE), depersonalisation (DP) and low levels of personal achievement (PA). Burnout is thought to be a progressive experience, often precipitated by circumstances within the work place of ongoing stress (Maslach, 1982). Emotional exhaustion refers to a state of fatigue, when an individual's emotional capacity is depleted or in some cases empty (Arches, 1997; Koeske & Koeske, 1993; Pines, 2005). Depersonalisation concerns the often negative or cynical attitudes held by the professional towards the

service user, which often leads to the dehumanisation of service users (Corders & Doherty, 1993). Finally, a diminished sense of personal accomplishment refers to the professional's negative self-evaluation in relation to his or her competence and success in work (Cordes & Dougherty, 1993). There has been some evidence to suggest depersonalisation is precipitated by emotional exhaustion and leads to a diminished sense of personal achievement (Leiter, 1988; Leiter & Maslach, 1988; Leiter & Meechan, 1986), although the precise nature of the interaction is unclear (Lewin & Sager, 2007).

### **Staff Burnout**

Professionals working within mental health services, including nurses, social workers, psychiatrists and psychologists, are considered to be at the highest risk of experiencing burnout (Snibbe, Radcliffe, Weisberger, Richards & Kelly, 1989; Thomsen, Soares, Nolan, Dallender & Arnetz, 1999). Indeed a recent review by Morse, Salyers, Rollins, Monroe-DeVita and Pfahler (2012) found that 67% of mental health professionals at any given time are experiencing some level of burnout. Burnout is thought to be greater in professionals working in community settings than inpatient settings (Carson, Leary, de Villiers, Fagin & Radmall, 1995; Prosser, 1996), with this staff group reporting higher levels of EE and DP (Onyett, 1997; Priebe, Fakhoury, Hoffman & Powell, 2005). It has been noted community mental health staff have additional stressors specific to their role (Edwards, Burnard, Coyle, Fothergill & Hannigan, 2000) and lower levels of psychological well being compared to ward based staff (Prosser et al., 1999). However, some evidence exists to suggest those working in community settings have higher levels of personal accomplishment (Carson et al., 1995).



Such a high level of burnout within mental health staff is of concern for a number of reasons. First, at the individual level, staff themselves experience poor physical and mental health as a result of burnout (Lee & Ashforth, 1996; Rohland, 2000). Second, at an organisational level, burnout is associated with a number of detrimental consequences such as reduced productivity and effectiveness of the workforce, increase in sick leave and the associated costs, and high turnover of both qualified and unqualified staff (Burke & Richardsen, 1993; Cropanzano, Rupp & Byrne, 2003; Preibe et al., 2004). In addition, unsurprisingly, organisational problems and negative attitudes held by staff experiencing depersonalisation also lead to poorer treatment outcomes for service users (Holmqvist & Jeanneau, 2006).

A number of theoretical models of burnout have been postulated (see Stalker & Harvery, 2002 for a review), including the Conservation of Resources Theory of Stress (Hobfoll, 1989; Hobfoll & Freedy, 1993), Transactional Model of Occupational stress (Cox, Kuk & Leiter, 1993), Demand Control Model (cited by Soderfeldt et al. 1997) and, specific to social workers, the Stress Strain Outcome Model (Koeske & Koeske, 1993). Although these theories all place emphasis on different aspects within the model, they all incorporate the impact of stressors, demands, resources, social support and coping styles on burnout, placing greater emphasis on the role of job and organisational characteristics above and beyond individual factors (Stalker & Harvey, 2002).

### **Aims and rationale of the current review**

There is evidence to suggest high levels of burnout within mental health professionals, specifically those working within community based services (Onyett, Pillinger & Muijen, 1997; Priebe et al., 2005; Prosser, 1996). Given the high levels of burnout in mental health staff it is important to understand what factors may influence

burnout in order to try to reduce these and target interventions at the most salient areas. Theoretical models of burnout exist, which go some way to explain the development of burnout (Hobfoll, 1989; Hobfoll & Freedy, 1993; Koeske & Koeske, 1993). However, these models lack sufficient supporting research and it is not clear to what extent these factors would be relevant in a mental health setting across professional groups. Thus, it appears imperative that current literature is systematically reviewed and synthesised to provide a comprehensive account of the potentially influencing factors. Consequently this review will examine the associates of burnout, considering both individual and organisational factors.

A number of previous reviews have focused on associates of burnout solely within one occupation, such as mental health nursing (Edwards et al., 2000; Melchior, Bours, Schmitz & Wittich, 1997) or social work (Coyle, Edwards, Hannigan, Fothergill & Burnard, 2005). However, these fail to view burnout in the wider context of multi disciplinary teams, which is common among community mental health services (Carpenter, Schneider, Brandon & Wooff, 2003). Onyett (2011) addresses this failing to some extent by providing a review of the factors associated with burnout in community staff. However, he only included papers concerning factors that had been identified by participants in his previous empirical paper (Onyett et al., 1997), which although valuable neglects a number of potential factors identified in additional studies. Furthermore, the papers included in Onyett's (2011) review are predominantly UK based, some utilise qualitative methodology, and some studies include inpatient as well as community staff. Other previous reviews are narrative in nature and thus have not systematically and comprehensively searched the literature (Morse, et al., 2012; Paris & Hoge, 2009). In addition, the above reviews do not consider the quality of the included studies when drawing conclusions.

Consequently, this review will synthesis recent international research considering factors related to burnout in all professionals working within community based mental health services to provide a detailed, comprehensive and coherent account of this issue. Given levels of burnout are high in community mental health professionals (Carson, et al., 1995; Onyett et al. 1997; Priebe, et al., 2005) developing an understanding of the associates of burnout may help direct organisations in supporting the needs of its staff.

## **Method**

### **Search Strategy**

In order to identify and retrieve relevant citations, five electronic databases (Academic Search Complete, PsycINFO, CINAHL, Medline and EMBASE) were searched using the following terms within the abstract: (Burnout OR Occupational Stress OR Organisational Stress OR Morale) AND (Mental Health OR Psychiatric OR Mental Illness OR Mental disorder) AND (Staff OR Workers OR Employees OR Practitioners OR Professionals OR Clinician). The search was not restricted by time period.

### **Inclusion and Exclusion Criteria**

Quantitative studies assessing the associates of burnout within mental health professionals working with adults within a community based setting (e.g. community mental health team, assertive outreach team, crisis resolution and treatment team, specialist personality disorder services) was included in this review. The introduction and method of included papers was carefully reviewed to determine the context in which staff worked. If this was ambiguous, papers were excluded. For example Lloyd and King (2004) included a sample of occupational therapists and social workers

working in 'public mental health' but failed to provide adequate information pertaining to the context in which these participants worked (e.g. community or inpatient, adult or child services). Where recruited participants worked in a variety of settings (e.g. community, acute inpatient units, voluntary services, educational facilities), papers were only included if the results were analysed as subsamples so that the data of interest could be extracted.

Professional background was not an exclusion criteria when staff worked within multi-disciplinary teams (e.g. mental health nurses, social workers, occupational therapists, psychologists and psychiatrists). Furthermore, papers solely utilising staff from a particular professional background were included when those professionals worked within community settings. For example, the paper by Edwards et al. (2006) was included as all the psychiatric nurses worked within community mental health settings whereas Gilbar (1998) was excluded as the social workers worked within a variety of physical and mental health settings.

Studies utilising a mixed methodology were examined and where possible quantitative results were incorporated into this review. Those using a purely qualitative methodology were excluded. Included studies were required to assess burnout using a standardised, psychometrically valid questionnaire and the search was further restricted to peer reviewed articles written in English.

Studies assessing burnout in mental health professionals working within learning disability services or child and family services were excluded, as were those employed within adult residential, inpatient or secure settings. Studies concerned with interventions to reduce staff burnout, developing a measure of burnout and papers simply citing levels of burnout were excluded from this review.

## **Results**

### **Search Results**

Initial searching resulted in 1,724 possible citations, which was reduced further once duplicates were identified and removed. All citations were then reviewed in accordance with the inclusion and exclusion criteria described above. Initial examination was based on information detailed in the abstract, which identified 96 potentially eligible papers. The full text of all 96 papers were then examined, leading to the exclusion of a further 71 articles. Thus 25 papers were deemed eligible for inclusion in the review from the electronic searches. A further 29 papers were identified following manual examination of the reference list of the included papers and previous reviews within the field (e.g. Edwards et al., 2000), three of which met inclusion criteria. A flow chart of the selection process can be found in Figure 1.

### **Quality assessment**

A quality assessment was carried out on all 28 studies that met the inclusion criteria. This quality assessment was generated by the author based on the STROBE guidelines for cross-sectional research (Von Elm et al., 2008, see appendix 1-B) and incorporates literature pertaining to the study of burnout. The quality assessment (see appendix 1-C) focused on aspects of methodology and analysis, rewarding one point to each met criterion, with a total of 10 available points. All studies were assessed using this criteria, although no papers were excluded as a result. Quality limitations are discussed when synthesising the results of the reviewed papers. The quality score for each paper can be found in appendix 1-D.

### **Measurement of burnout and related variables**

Questionnaires were used in all 28 studies to assess levels of burnout within mental health staff. All studies used a version of the Maslach Burnout Inventory (MBI;

Maslach & Jackson, 1981; 1986; Maslach, Jackson & Leiter, 1996). The MBI comprises questions assessing EE, DP and PA. Higher scores on both the EE and DP, and lower scores on the PA subscales indicate high levels of burnout.

A number of social, personal, work and organisational factors were assessed using questionnaires in all 28 studies. For example, 15 studies employed questionnaires pertaining to job satisfaction, 10 used measures assessing stress or staff mental health, four measured role conflict or ambiguity and four gave details of the measures used to assess support or supervision. A full list of the measures used in the reviewed studies can be found in appendix 1-D.

### **Participant Characteristics**

A total of 6,083 community based mental health staff participated in 28 studies, with sample sizes ranging from 10 to 813. All 28 studies incorporated results from male and female staff, however the majority of participants were female (ranging from 51% to 96%). Where stated the mean age of participants ranged from 34 to 46 years old, although only 17 studies reported this descriptive statistic. Only six papers reported whether participants were married or cohabitating (ranging from 42% to 78%). Half of the studies included staff from more than one professional background, whereas six studies focused solely on social workers, four papers only included psychiatric nurses and three studies collected data from case managers, psychiatric workers or rehabilitation practitioners. Two papers (Boyer & Bond, 1999; Schulz, Greenley & Brown 1995) gave insufficient information about the professions of the participants included. Two papers also included a small percentage of administrative staff in their sample (Onyett et al., 1997; Wykes, Stevens & Everitt 1997). The inclusion of administrative staff is considered in the quality assessment.

Mean levels of EE, DP and PA, according to the MBI (Maslach & Jackson 1981; 1986; Maslach et al., 1996), were reported in 22 of the 28 studies. These means ranged from 1.7 to 27.4 for EE, 1.0 to 9.9 for DP and 4.7 to 40.3 for PA. It is worth noting Blau, Tatum and Ward Goldberg (2013) and Salyers and Bond (2001) reported considerably low subscale means, thus increasing the range between scores.

### **Statistical Analysis**

The majority of studies included in this review employed a form of correlational analysis (either parametric or non-parametric) to suit the cross-sectional design. 16 studies also included a regression analysis (e.g. linear or multiple), five included t-tests, seven included an analysis of variance (ANOVA) and one utilized an analysis of covariance (ANCOVA). Appendix 1-D depicts a comprehensive account of statistical analysis used, along with the main findings of each study. Only one paper reported a prospective power calculation (Galeazzi, Delmonte, Fakhoury & Priebe, 2004) and one paper commented on having inadequate power (Walsh & Walsh, 2002). Degree of effect size was not an exclusion criteria when reporting results. However, papers reporting a small effect size (0.1 for correlations, 0.3 for t-tests and less than 0.25 for ANOVA; Cohen, 1988) are highlighted throughout the review.

### **Key findings of the studies**

Due to the heterogeneity of the papers a meta-analysis could not be performed and instead a narrative synthesis is provided. The results of the reviewed papers were placed into eight domains pertaining to staff burnout, including socio-demographics, work demographics, job stress and demand, support and supervision, individual characteristics, client characteristics, role perception and team context. Each of these will be considered in turn below.

**Socio-demographics**

Several studies commented on the relationship between an aspect of the sample socio-demographics and staff burnout. The most commonly cited socio-demographic variables were age, gender, education, family status and ethnicity.

Thirteen papers reported the relationship between age and staff burnout. Both Wykes, Stevens and Everitt (1997) and Schulz, Greenley and Brown (1995) found age was not related to burnout when measured as a whole concept, however Boyer and Bond (1999) found burnout correlated negatively with age. Interestingly, when burnout was broken down into the three conceptual categories of EE, DP and PA a different picture appears. With regard to EE, four papers found a significant correlation with age. Blau et al. (2013), Nelson, Johnson and Bebbington (2009) and Salyers and Bond (2001) found older staff members to have lower levels of EE whereas Galeazzi et al. (2004) found higher EE in older staff. Only Jayarante and Chess (1984) found age was not significantly associated with EE, which may be a result of inadequate power given their sample size. The remaining papers did not report this statistic. Seven papers reported the relationship between DP and age (Acker, 2003; 2008; Billings et al., 2003; Blau et al., 2013; Edwards et al., 2006; Nelson et al., 2009; Salyers & Bond, 2001), with all but one (Acker, 2003) reporting lower levels of DP in older staff, specifically when aged 55 or over (Billings et al., 2003). Again, Jayarante and Chess (1984) found age was not significantly associated with DP. In terms of diminished PA three out of the four studies reported a negative correlation, with lower PA in younger staff (Acker, 2003; 2008; Blau et al., 2013), but again as with EE Galeazzi et al. (2004) found the converse effect. In summary, the majority of papers suggest older staff have lower levels of EE and DP, and a higher sense of PA.



Eleven studies commented on the relationship between burnout and gender. When burnout was considered as a whole construct no relationship with gender was observed (Boyer & Bond, 1999; Schulz et al., 1995; Wykes et al, 1997). However, Preibe, Fakhoury, Hoffmann and Powell (2005) found when gender was included in a regression analysis being male predicted lower levels of burnout, although this only achieved a small effect size. There was evidence to suggest being male was associated with higher levels of DP (Acker, 2003; Billings et al., 2003; Edwards et al., 2006; Evans et al., 2006; Hannigan, Edwards, Coyle, Fothergill & Burnard, 2000). In contrast, Blau et al. (2013) noted higher levels of DP in females with gender explaining 16% of the variance in DP. However, this sample had a high proportion of females (73%), potentially resulting in a type one error. Few papers reported the relationship of both EE and PA with gender. Only Walsh and Walsh (2002) and Acker (2003) commented on this relationship and portrayed conflicting results. Walsh and Walsh (2002) found a significant relationship between high levels of EE and being male, whereas Acker (2003) found no relationship between EE or PA and gender. Although there appears to be evidence DP is associated with gender, firm conclusions cannot be drawn about the relationship between this variable and EE or PA.

Of the 28 studies included in the review, eight specifically reported the relationship between ethnicity and burnout. Only one study, Boyer and Bond (1999), correlated burnout as a whole construct with ethnicity, and found no relationship. The remaining studies all found an association between being from a minority ethnic group and lower levels of EE (Acker, 2008; Billings et al., 2003; Nelson et al., 2009; Prosser et al., 1999; Salyers & Bond, 2001; Wykes et al, 1997) and higher levels of PA (Acker, 2008, Salyers & Bond, 2001) and, all except one found a similar

relationship for DP (Billings et al., 2003; Nelson et al., 2009; Webster & Hackett, 1999; Prosser et al., 1999; Salyers & Bond, 2001; Wykes et al., 1997). To further explore the relationship between ethnicity and burnout Salyers and Bond (2001) performed an ANCOVA to control for the influence of demographic variables on EE and DP. When age was controlled for, ethnicity still had a significant association with EE, but not DP. In summary, a number of studies provide evidence to suggest an association between ethnicity and both EE and DP. However, there is evidence to suggest this relationship may not remain when other variables are controlled for and as such further research is needed.

Four papers commented on the relationship between family status and burnout. When considered as a whole construct burnout was not associated with family status (Boyer & Bond, 1999). Interestingly, Acker and Lawrence (2009) reported a relationship between EE and family status, with childless staff having higher levels of EE, but this should be considered in light of their relatively low quality criteria score. Furthermore, Acker (2003; 2008) found no relationship between EE, DP or PA and it is unlikely these are as a result of being underpowered as both papers had an adequate sample size. The majority of research suggests there is no relation between family status and burnout, however, considering all papers except one were by the same author, biases may be present.

The relationship between staff levels of education and burnout has also been considered. Conflicting evidence occurs in relation to burnout as a whole construct and level of education. Schulz et al. (1995) found education had a direct effect on burnout, with higher levels found in those with higher levels of education, whereas Boyer and Bond (1999) found no relationship. However, the results reported by Schulz et al. (1995) should be considered in light of their poor quality criteria score.

Four of the papers reviewed commented on the relationship between dimensions of burnout and education with all finding that staff with higher levels of education report higher levels of EE (Acker, 2003; 2008; 2011; Blau et al., 2013). However, Blau et al., (2013) found education, along with personal involvement, only explained a small amount of variance in EE (3%), and so its impact may be limited. Few papers reported the relationship between DP and education. In her 2003 paper, Acker found a positive relationship between education and DP but this was not confirmed in her 2008 paper where a non-significant relationship was observed. Only Acker (2003) commented on the relationship with PA and found it was not associated with education. In summary, education is related to EE but results are inconclusive with regard to DP and PA. Furthermore, as with family status, a number of papers are written by the same author, which may result in biases.

### **Work demographics**

The relationship between burnout and a variety of work related demographic factors were reported in the papers reviewed. When considered as a whole construct, burnout did not correlate with years of service but negatively correlated with years in current position (Boyer & Bond, 1999). In contrast, Schulz et al. (1995) found length of service explained 12% of the covariance in burnout but this result should be considered in light of their poor quality score. Eight papers commented on the relationship between length of service and the dimensions of burnout. With regard to EE, four out of six papers found a negative relationship, where longer periods of service related to lower levels of EE (Blau et al., 2013; Nelson et al., 2009; Billings et al., 2003; Galeazzi et al., 2004). A similar result was observed for DP (Billings et al., 2003; Blau et al., 2013; Galeazzi et al., 2004; Hannigan et al., 2000; Nelson et al., 2009). However, Acker (2003; 2008) provided contrary evidence to the perceived

relationship between EE, DP and length of service citing no association. Only two papers commented on this result for PA, reporting longer service was related to greater PA (Acker, 2003; 2008). The sample used by Acker (2003; 2008) consisted of solely social work professionals, whereas the remaining papers used a variety of professionals. Thus it may be important to consider whether professional background influences the relationship between burnout and length of service and if this could account for the conflicting results observed in this review.

A number of papers point towards differing levels of burnout between professionals. Of those studies reporting the relationship between professional background and burnout as a whole construct, most found no relationship (Schulz et al., 1995; Wykes et al, 1997). The exception to this is Priebe et al. (2005) who reported burnout was higher in psychiatrists. However, this result was only confirmed in the London sample, and not staff working in Berlin, so contextual factors may be an important consideration in interpreting this result. When considering the individual dimensions of burnout psychologists were consistently found to have lower levels of DP (Billings et al., 2003; Nelson et al., 2009; Prosser et al., 1999), whereas psychiatric nurses and social workers had higher levels of EE (Prosser et al., 1999). Managers and nurses in post qualification training roles had higher levels of PA (Hannigan et al., 2000), as did support workers (Billings et al., 2003). A mixed picture appears with regard to psychiatrists. Galeazzi et al. (2004) found psychiatrists had higher levels of DP and EE, whereas Billings et al. (2003) found psychiatrists had lower EE than other professions. It is worth noting a number of studies included in this review utilised staff from one professional background and as such, may not have comprehensively assessed the potential impact of this factor.

Eight papers also considered the relationship between burnout and caseload size. The majority of the studies that investigated this relationship found no association between caseload and EE (Acker, 2003; 2008; 2011; Haj-Yahia, Bargal & Guterman, 2000; Onyett et al., 1997), DP (Acker, 2003; 2008; Onyett et al., 1997) or PA (Acker, 2003; 2008; Haj-Yahia et al., 2000). Only Walsh & Walsh (2002) found as caseload increased, DP increased and Boyer and Bond (1999) found caseload size was positively correlated to burnout.

Finally, staff in inner city areas reported higher levels of burnout compared to those in rural areas (Hannigan et al., 2000; Priebe et al., 2005; Wykes et al., 1997). Other work-related demographic factors (e.g. job security, perceived dissatisfaction with role, opportunity for professional development and perceived service efficacy) were only considered in one paper and thus conclusions pertaining to these are not discussed in detail as further evidence is needed.

There is clear evidence to suggest a relationship between burnout and certain social and work related demographic factors. Indeed, social and work demographic sets predict burnout in regression analyses (Acker, 2003; 2008; 2011; Blau et al., 2013; Walsh & Walsh, 2002). Conflicting results about the individual aspects of both social and work related demographic characteristics make it difficult to conclusively tease out what relationships might exist with each variable. However, ethnicity, age, gender and education appear to have a consistent relationship with one or more dimensions of burnout.

### **Job Stress and Demand**

Some papers discussed the relationship between job stress, demand and staff burnout. Unsurprisingly, all four papers that investigated the impact of stress found a significant relationship with all the dimensions of the MBI. Greater stress was related

to higher levels of EE and DP, as well as lower levels of PA (Acker, 2008; 2011; Hannigan et al., 2000; Wykes et al, 1997). No clear picture emerged regarding the relationship between job demand and burnout, however all studies used differing measures of demand, which may explain the inconsistencies observed. Both Fielding and Weaver (1994) and Evans et al. (2006) found as demand increased, levels of EE increased, whereas Walsh & Walsh (2002) reported a negative relationship and Jayarante and Chess (1984) did not find any association. DP was not associated with demand in most studies reporting this statistic (Evans et al., 2006; Fielding & Weaver, 1994; Jayarante & Chess, 1984), the only exception being Walsh and Walsh (2002) who found as demand increased DP increased. Only one paper considered the relationship between PA and clinical activity, reporting a significant negative relationship (Walsh & Walsh, 2002). In summary, there is some evidence suggesting staff who are more stressed have higher levels of EE, DP and diminished PA. However, the influence of job demand has not been measured with sufficient frequency or consistency to draw firm conclusions.

### **Support and Supervision**

Eleven studies investigated the impact of social support, workplace support or clinical supervision. Staff who described having adequate mechanisms of support in general had lower levels of EE (Acker, 1999). Four studies considered the relationship between burnout and support outside of work. When burnout was assessed as a whole construct, no relationship was found (Wykes et al, 1997). However, when the individual dimensions of burnout were correlated with social support three studies found lower levels of satisfaction with social support were related to higher levels of EE (Acker, 2003; Acker & Lawrence, 2009; Evans et al., 2006). However, when the work environment, personal characteristics of participants and their subjective

feelings were accounted for, low social support with not associated with EE (Evans et al., 2006). This suggests the relationship between social support and burnout may not be straightforward. Social support was not associated with DP or PA (Acker, 2003).

In terms of the workplace, four studies commented on the influence of support from colleagues on burnout. Acker (2003; 2011) found lower levels of EE in participants who reported higher levels of workplace support, including support from co-workers and supervisors. Furthermore, Hannigan et al. (2000) found participants who had unsupportive managers had higher levels of EE and DP. In contrast, Fielding and Weaver (1994) did not find an association between support and EE but may not have adequate power to detect a relationship due to a small sample size. Lastly, support from colleagues was not associated with DP or PA (Acker, 2003; Fielding & Weaver, 1994).

Clinical supervision has been widely regarded as an important practice for all healthcare professionals (Golia & McGoven, 2013). Surprisingly, only two studies explicitly commented on the relationship between clinical supervision and burnout (Edwards et al., 2006; Webster & Hackett, 1999). Despite using different measures of clinical supervision, both found higher scores were associated with lower levels of DP and EE. In addition, Edwards et al. (2005) found community nurses who experienced at least 6 sessions of clinical supervision in their present post had lower levels of DP. Only Edwards et al., (2006) reported the impact of supervision on PA, suggesting no relationship. Finally, Martin and Schinke (1998) found participants who reported having received harsh criticism from a supervisor reported higher levels of burnout. Although the evidence base is very limited, a tentative conclusion suggests support from colleagues, family and friends and supervisors had a positive impact on EE

amongst mental health professionals. More research is needed to draw firm conclusions about the impact of support on levels of DP and PA.

### **Individual characteristics**

At present, there is limited evidence about the individual characteristics of staff that may relate to levels of burnout. However, a small number of studies have eluded to the potential impact of staff self perceptions on levels of burnout. Studies have noted EE was higher in staff with lower levels of perceived competence (Acker & Lawrence, 2009) and those who struggled to makes decisions (Evans et al., 2006). However, this was not observed when other variables such as work characteristics were accounted for (Evans et al., 2006). Staff who did not feel valued by their employer had higher levels of DP (Evans et al., 2006), as did those who did not identify with their profession (Onyett et al., 1997).

Only three papers discussed the relationship between staff mental health and burnout. Scores on the General Health Questionnaire (GHQ-12; Goldberg & Williams, 1988) were found to positively correlate with EE and DP, and negatively correlate with PA (Fielding & Weaver, 1994; Hannigan et al., 2000; Wykes et al, 1997). Only Wykes et al. (1997) considered the relationship between burnout and anxiety, noting scores on the Beck Anxiety Inventory (BAI; Beck, 1990) positively correlated with EE and DP. They did not report on the relationship with PA. Staff who had higher levels of self esteem had lower levels of EE and DP and higher levels of PA (Hannigan et al., 2000). Lastly, expressed emotion was not associated with any dimensions of burnout (Oliver & Kuipers, 1996) but this result should be considered in light of the low quality assessment criteria score of this paper.

### **Client Characteristics**



Seven papers considered the relationship between burnout and client characteristics. When considering burnout as a whole construct, no relationship was found with clients' symptom severity or functioning (Schulz et al., 1995) or number of hospital admissions (Boyer & Bond, 1999; Schulz et al., 1995). Nor was there any relationship with the percentage of clients experiencing homelessness or severe and enduring mental health difficulties, or those using drugs (Boyer & Bond, 1999; Onyett, 1997). Three papers found that staff who work with clients with severe and enduring mental health difficulties have higher levels of EE than staff working with clients with mood or interpersonal related difficulties (Acker, 1999; 2011; Acker & Lawrence, 2009). However, Acker (2003) and Onyett et al. (1997) did not find a relationship between problem severity, client functioning and EE. There also seems to be a mixed picture with regard to DP. Acker (1999) found as involvement with clients with severe mental health difficulties increased, levels of DP also increased. However, this was not supported in her 2003 paper, despite using the same measure and professional group. No studies reported associations between PA and client characteristics. Thus, research is inconclusive with regard to the relationship between client characteristics and burnout.

### **Role Perception**

Several papers considered the relationship between burnout, role conflict and ambiguity, satisfaction, autonomy and job challenge. Role conflict refers to staff perceptions about the incompatible competing demands of their job whereas role ambiguity reflects a lack of clarity regarding the requirements of a job (Haj-Yahia et al., 2000). A number of the results reported for role perceptions only reached a low-medium effect size, which should be considered when drawing conclusions. Only three papers (Acker, 2003; Haj-Yahia et al., 2000; Jayarante & Chess, 1984)

considered the relationship between burnout and role conflict. Two papers found higher levels of EE were associated with higher levels of role conflict (Acker, 2003; Haj-Yahia et al., 2000), whereas Jayarante and Chess (1984) found role conflict was not significantly associated with EE. However, Jayarenta and Chess (1984) had a small sample and so may not have had adequate power to detect a relationship. There was disagreement about the relationship between DP and role conflict, with Acker (2003) reporting a positive correlation and Haj-Yahia et al. (2000) and Jayarante and Chess (1984) suggesting no correlation. Again, it is worth noting both Haj-Yahia et al. (2000) and Jayarenta and Chess (1984) had a small sample and so may not have had adequate power to detect a relationship between DP and role conflict. Lastly, only Acker (2003) considered the relationship between PA and role conflict stating there was no relationship.

With regard to role ambiguity, seven papers commented on its relationship to burnout. Greater role ambiguity was found to increase levels of EE and DP (Acker, 2003; Fielding & Weaver, 1994; Jayarante & Chess, 1984; Onyett et al., 1997; Walsh & Walsh, 2002). In contrast, Haj-Yahia et al. (2000) did not find a significant relationship. However, as with role conflict, methodological limitations could account for this discrepancy. The papers reviewed also suggested a relationship between PA and role ambiguity where staff reporting greater role clarity reported higher levels of PA (Acker, 2003; Haj-Yahia et al., 2000; Onyett, 1997; Walsh & Walsh, 2002).

Furthermore, when considering mediating variables Schulz et al. (1995) found an indirect effect of job clarity, through work satisfaction, on burnout as whole construct.

Despite 15 papers including measures of job satisfaction, only five papers reported results relating to this. Of the five papers who discussed job satisfaction, only two found a relationship with burnout (Schulz et al., 1995; Evans et al., 2006), with

the remaining reporting non significant results regarding the dimensions of burnout (Martin & Schinke, 1998; Haj-Yahia et al., 2000; Galeazzi et al., 2004). The exception to this is Haj-Yahia et al. (2000) who found a significant relationship between job satisfaction and PA, although this was a small effect size. However, methodological limitations, as represented in the assigned quality score, may account for this lack of significance. Only one paper commented on the relationship between burnout and job challenge (the extent to which staff utilise their skills and knowledge and are interested in their job) noting staff with lower levels of job challenge had higher levels of EE and DP (Haj-Yahia et al., 2000). Thus, there is limited, consistent evidence to conclusively report on the relationship between job satisfaction and burnout.

Staff autonomy and mastery has been investigated in a limited number of papers and inconsistencies appear. When burnout was considered as a whole, Schulz et al. (1995) found staff autonomy had an indirect effect on burnout through work satisfaction and when entered into a regression analysis contributed to 2% of the variance in burnout. Haj-Yahia et al. (2000) found autonomy and mastery negatively correlated with EE, DP and positively correlated with PA. However, Fielding and Weaver's (1994) did not support this claim citing no relationship between any of the dimensions of burnout. Interestingly, when worker power was correlated with EE, DP and PA, Haj-Yahia et al., (2000) did not find a significant relationship, which perhaps highlights methodological discrepancies in Haj-Yahia et al.'s (2000) work, as the measures assessing mastery and power appear to assess similar things.

In summary, research suggests high levels of role conflict and ambiguity is associated with high levels of EE, and the latter also with DP and PA. Methodological

limitations restrict the conclusions that can be made with regard to job satisfaction and burnout, and as such further robust research into this relationship is needed.

### **Team Context**

Four papers consider the relationship between burnout and team context, including leadership, team structure and identification, goal congruence and culture. Leadership was correlated with both EE and DP but not PA (Webster & Hackett, 1999) and had an indirect effect on burnout through job satisfaction (Schulz et al., 1995). Team identification and conflict was associated with burnout as a whole construct (Onyett et al., 1997; Galeazzi et al., 2004) and identification was found to correlate with EE, DP and PA (Onyett, 1997). Furthermore, reporting team conflict as a source of stress was predictive of scores in EE (Galeazzi et al., 2004). In summary, there is some evidence to suggest influence of team context on levels of burnout but further research is needed to draw comprehensive conclusions.

## **Discussion**

### **Summary of findings**

This systematic literature review sought to identify the factors related to burnout in community mental health staff. Several domains were identified from the papers reviewed including socio-demographics, work demographics, job stress and demand, support and supervision, individual characteristics, client characteristics, role characteristics and team context. Despite inconsistencies of the results within domains a number of conclusions could be made. Lower levels of EE were associated with age (being older), being from a minority ethnic group, higher levels of education, longer length of service, less perceived stress and role ambiguity, lower scores on the GHQ and high levels of adequate social and work related support. Lower levels of DP were

related to age (being older), being from an ethnic minority, longer length of service, less perceived stress and role ambiguity and higher levels were associated with being male and having higher scores on the GHQ. Fewer studies commented on the relationship between burnout and PA but of those that did there was consistency that a greater sense of personal accomplishment is observed in older staff, those with lower scores on the GHQ, those from a minority ethnic group and when less role ambiguity is reported.

Both the Demand-Control model (cited by Soderfeldt et al. 1997) and the Transactional Model of Occupational Stress (Cox et al., 1993) suggest the organisation staff work within determines the extent to which staff become burnt out. They hypothesize this is due to the high levels of control systems have on the extent to which staff are in demand and able to practice autonomously (Soderfeldt et al. 1997; Cox et al., 1993). Indeed, this review suggests the impact of a number of organisation factors on levels of burnout, such as role perceptions (ambiguity and conflict), support and stress. Previous reviews have highlighted the influence of additional organisational factors such as leadership style, decision-making, cohesion, autonomy and success on levels of burnout (Stalker & Harvey, 2002). This review also considered many of these factors, however a limited number of papers explored these variables and as such, further research is needed in order to draw firm conclusions about the relationship between these additional organisational factors and burnout.

Consistent with previous models of burnout (Cox et al., 1993; Hobfoll, 1989; Hobfoll & Freedy, 1993; Koeske & Koeske, 1993) and reviews (Coyle et al., 2005; Melchoir, Bours, Schmitz & Wittich, 1997; Onyett, 2011; Stalker & Harvey, 2002) the findings of this review suggest the role of social and work related support and

supervision play a role in reducing levels of burnout. It has been hypothesised that social and work related support builds levels of resilience in staff, due to the impact on self-esteem and confidence (Acker & Laurence, 2009).

Despite a plethora of the reviewed studies including measures of job satisfaction only five commented on an association (either significant or non-significant) with burnout. In contrast to the current review, previous reviews have commented on the significant association between satisfaction and burnout, noting the co-existence of high levels in both (Onyett, 2011). Authors have attempted to explain this phenomenon by suggesting the high levels of work commitment found in those with increased job satisfaction, contributes to emotional exhaustion due to the continued expenditure of time and energy on work related tasks (Chernis, 1995; Kumar, Fischer, Robinson, Hatcher & Bhagat, 2007). Given the lack of research into job satisfaction observed within this review, and the potential impact of methodological limitations on the reported results, further research is needed in order to draw firm conclusions about the association between satisfaction and burnout, and the process underlying this.

### **Methodological Limitations**

Despite reviewing a large number of papers, the evidence base for the factors associated with burnout is relatively weak. Few papers scored above six on the quality assessment, which, as previously described in other reviews (Paris & Hodge, 2009), suggests methodological rigour is often nascent. Only two studies discussed the power of their samples, which further contributes to a difficulty in determining the credibility of the findings drawn, and the same group of researchers authored a number of papers. Furthermore, a number of studies only reported results for certain dimensions of the MBI (Maslach & Jackson, 1981; 1986; 1996) but used the whole

scale (as detailed in their method section) often failing to report results for the PA subscale. Although, this could infer a lack of significant results, without this being documented it is hard to produce a comprehensive account of the factors pertinent to all the dimensions of burnout.

A number of the reviewed papers also had relatively poor response rates (e.g. a 50% response rate in Hannigan et al., 2000) and so it may be that the studies included were not getting an accurate representation of staff working within community services. Furthermore, many papers were restricted to determining the relationship between burnout and one or two factors and as such a number of factors only had a limited number of papers contributing to the conclusions drawn. The review drew on literature from a number of nationalities, which although could be seen as a positive, could also be detrimental due to differing mental health systems, and thus differing community services, within each country. This meant it was difficult to determine whether the participant group used within the reviewed studies was homogenous and whether this was an accurate representation of community based services.

Consequently, it would be beneficial for future mental health research from a variety of research groups internationally to robustly consider the link between burnout and a number of variables in order to strengthen the evidence base, particularly around clinical supervision, client characteristics and team context.

### **Theoretical Limitations**

All papers within this review measured burnout using a version of the MBI (Maslach & Jackson, 1981; 1986). However, despite the suggested inter-reliability observed between the individual dimensions (Cordes & Dougherty, 1993), it is unclear whether this measure (and the model from which it is derived), accurately

depicts the concept of burnout (Stalker & Harvey, 2002). A number of authors have suggested that the occurrence of high EE and DP with low PA rarely occurs in practice, with high PA often remaining even in the face of high EE (Onyett, 2011; Paris & Hodge, 2009). This suggests that despite feelings of fatigue and exhaustion staff are still able to emotionally connect with clients and experience a sense of achievement in their work (Paris & Hodge, 2009). Thus, it may be that EE is the central component of burnout and that DP and PA are potential consequences of EE (Cox, et al. 1993; Stalker & Harvey, 2002). Certainly this review found a greater number of significant results for EE when compared to DP and, even more so, PA. Additionally, this could further explain the inconsistencies between the results for burnout as a whole construct and the individual dimensions. Thus, the conclusions of this review may be limited and, like others before, suggests the need for qualitative research to consider the interplay of factors more clearly, which may be more complex than the current linear quantitative models assume, and furthermore, understand how staff maintain resilience and effective working relationships (Onyett, 2011; Cooperrider et al., 2003).

### **Clinical Implications**

The seven domains highlighted in this review may have implications for the prevention of burnout. Given the importance of support in reducing levels of EE, the introduction of peer supervision and reflective practice groups within community mental health services could reduce levels of burnout by increasing confidence and self direction (Agnew, Vaught, Fortune & Getz, 2000). Furthermore, given the lower levels of burnout found in older and more experienced clinicians, the ability for younger, inexperienced staff to access support from these team members may be incredibly valuable. Role ambiguity was also consistently observed to relate to higher



levels of burnout and therefore clear guidance on the tasks and demands expected of staff may be beneficial.

Considering the levels of burnout observed within the reviewed studies, and the variables associated with this, there is a strong argument for targeting interventions to reduce burnout within CMHT staff. A review of the prevention literature is beyond the scope of this paper, beside which, comprehensive reviews already exist (Awa, Plaumann & Walter, 2010; Morse et al., 2012; Stalker & Harvey, 2002). This review highlighted the importance of individual and organisational factors (e.g. support, role perceptions and stress) on levels of burnout, suggesting subsequent interventions should target both. Interventions aimed at reducing levels of burnout in staff can be either individual or organisational in focus. Many promote the latter, suggesting ways organisations can increase staff energy (to target EE), strong involvement (instead of DP) and efficacy (to promote personal involvement) (Maslach & Goldberg, 1998; Stalker & Harvey, 2002) rather than focusing on ways individuals can prevent burnout through coping, relaxation strategies and social support. There is some evidence to suggest interventions targeting both individual and organisational factors may be most beneficial (Awa et al., 2010).

## **Conclusions**

This systematic review aimed to determine the factors associated with burnout in community based mental health staff. Having performed a comprehensive search of relevant databases, 28 articles were identified and the findings were synthesised. Consequently, a number of potential factors were highlighted. The results indicated that social and work demographics, stress, support and role characteristics all play an important role in burnout. However further research is needed to determine the influence of a number of remaining factors. The findings are discussed in relation to

models of burnout, as well as considering the limitations of this review and the papers included.

### References

- \*Acker, G. (1999). The impact of clients' mental illness on social workers job satisfaction and burnout. *Health and Social Work, 24, 2*, 112-119.
- \*Acker, G. (2003). Role conflict and ambiguity. *Social Work in Mental Health, 1, 3*, 63-80.
- \*Acker, G. (2008). An examination of the relationship between workers and agencies characteristics and three outcome variables: burnout, role stress and intent to quit. *American Journal of Psychiatric Rehabilitation, 11*, 295-309.
- Acker, G. (2010). The Challenges in Providing Services to Clients with Mental Illness: Managed Care, Burnout and Somatic Symptoms Among Social Workers. *Community Mental Health, 46*, 591-600.
- \*Acker, G. (2011). Burnout among mental health care providers. *Journal of Social Work, 12, 5*, 475-490.
- \*Acker, G. & Lawrence, D. (2009). Social work and managed care: Measuring competence, burnout and role stress of workers providing mental health services in a manager care era. *Journal of Social Work, 9, 3*, 269-283.
- Agnew, T., Vaught, C. C., Fortune, J. & Getz, H. G. (2000). Peer group supervision fosters confidence and professionalism. *Professional School Counselling, 4, 1*, 6-12.
- Arches, J. L. (1997). Burnout and social action. *Journal of Progressive Human Services, 8(2)*, 51-61.
- Awa, W. L., Plaumann, M. & Walter, U. (2010). Burnout prevention: a review of intervention programs. *Patient Education and Counselling, 78, 2*, 184-190.
- Beck, A. T. (1990). *The Beck Anxiety Inventory*. New York, USA: Harcourt Brace Jovanovich.

- \*Blau, G., Tatum, D. S. & Ward Goldberg, C. (2013). Exploring correlates of burnout dimensions in a sample of psychiatric practitioners: a cross sectional study. *Psychiatric Rehabilitation Journal*, 36, 3, 166-172.
- \*Billings, J., Johnson, S., Bebbington, P., Greaves, A., Priebe, S., Muijen, M. et al. (2003). Assertive outreach teams in London: staff experiences and perceptions: Pan-London Assertive Outreach Study, Part 2. *The British Journal of Psychiatry*, 183, 139-147.
- \*Boyer, S. L. & Bond, G. R. (1999). Does assertive community treatment reduce burnout? A comparison with traditional case management. *Mental Health Services Research*, 1, 1, 31- 45.
- Burke, R. J., & Richardsen, A. M. (1993). Psychological burnout in organizations: Research and Intervention. In R. T. Golembiewski (Eds.), *Handbook of organizational behaviour*. (327-365). New York, USA: Marcel Dekker.
- Carpenter, J., Schneider, J., Brandon, T. & Wooff, D. (2003). Working in Multidisciplinary Community Mental Health Teams: The Impact of Social Workers and Health Professionals of Integrated Mental Health Care. *British Journal of Social Work*, 33, 1081-1103.
- Carson J., Leary J., de Villiers N., Fagin L. & Radmall J. (1995) Stress in mental health nurses: Comparison of ward and community staff. *British Journal of Nursing* 4, 579-581.
- \*Carson, J., Fagin, L., Brown, D., Leary, J. & Bartlett, H. (1997). Self-esteem in mental health nurses: Its relationship to stress, coping and burnout. *NT Research*, 2, 5, 361-369.
- Cherniss, C. (1995). *Beyond Burnout*. London, UK: Routledge

- Cohen J. (1988). *Statistical power analyses for the behavioural sciences*. New York, USA: Academic Press.
- Cooperrider, D.L., Whitney, D., & Stavros, J. (2003). *Appreciative Inquiry Handbook: The First in a Series of AI Workbooks for Leaders of Change*. Bedford Heights, USA: Lake Shore Communications.
- Cordes, C., & Dougherty, T. (1993). A review and an integration of research on job burnout. *The Academy of Management Review*, 18, 621-656.
- Cox, T., Kuk, G., & Leiter, M. P. (1993). Burnout, health, work stress and organisational healthiness. In W. Schaufeli & C. Maslach & T. Marek (Eds). *Professional burnout: Recent developments in theory and research* (pp. 177-193). USA: Taylor & Francis.
- Coyle, D., Edwards, D., Hannigan, B., Fothergill, A. & Burnard, P. (2005). A systematic review of stress among mental health social workers. *International Social Work* 48, 2, 201-211.
- \*Crawford, M. J., Adedeji, T., Price, K. & Rutter, D. (2010). Job satisfaction and burnout among staff working in community-based personality disorder services. *International Journal of Social Psychiatry*, 56, 196-206.
- Cropanzano, R., Rupp, D. E., & Byrne, Z. S. (2003). The relationship of emotional exhaustion to work attitudes, job performance, and organizational citizenship behaviors. *Journal of Applied Psychology*, 88, 1, 160-169.
- Edwards, D. Burnard, P., Fothergill, A. & Hannigan, B. (2000). Stress and burnout in community mental health nursing: a review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 7, 7-14.
- \*Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Juggessur et al. (2006). Clinical supervision and burnout: the influence of clinical supervision

for community mental health nurses. *Journal of Clinical Nursing*, 15, 1007-1015.

\*Evans, S., Huxley, P., Gatley, C., Webber, M., Mears, A., Pajak, S. et al. (2006).

Mental health, burnout and job satisfaction among mental health social workers in England and Wales. *British Journal of Psychiatry*, 188, 75-80.

\*Fielding, J. & Weaver, S. (1994). A comparison of hospital and community-based mental health nurses: perceptions of their work environment and psychological health. *Journal of Advanced Nursing*, 19, 1196-1204.

\*Galeazzi, G. M., Delmonte, S., Fakhoury, W. & Priebe, S. (2004). Morale of mental health professionals in community mental health services of northern Italian province. *Epidemiologia e Psichiatria Sociale*, 13, 2, 191-197.

Gilbar, O. (1998). Relationship Between Burnout and Sense of Coherence in Health Social Workers. *Social Work and Health Care*, 26, 3, 39-49.

Goldberg, D. & Williams, P. (1998). *A users guide to the General Health Questionnaire*. Windsor, UK: NFER- Nelson.

Golia, G. M. & McGovern, A. R. (2013). If you save me, I'll save you: The power of peer supervision in clinical training and professional development. *The British Journal of Social Work, Advance Access*, 1-17.

\*Haj-Yahia, M. M., Bargal, D. & Guterman, N. B. (2000). Perception of job satisfaction, service effectiveness and burnout among Arab social workers in Israel. *International Journal of Social Welfare*, 9, 201-210.

\*Hannigan, B., Edwards, D., Coyle, D., Fothergill, A. & Burnard, P. (2000). Burnout in community mental health nurses: findings from the all-Wales stress study. *Journal of psychiatric and mental health nursing*, 7, 127-134.

Hobfoll, S. E. (1989). Conservation of resources. A new attempt at conceptualizing

- stress. *American Psychologist*, *44*, 513-524.
- Hobfoll, S. E., & Freedy, J. (1993). Conservation of resources: A general stress theory applied to burnout. In W. Schaufeli & C. Maslach & T. Marek (Eds.), *Professional burnout: Recent developments in theory and research* (pp. 115-129). Washington, USA: Taylor & Francis.
- Holmqvist, R., & Jeanneau, M. (2006). Burnout and psychiatric staff's feelings towards patients. *Psychiatry Research*, *145*, 2-3, 207-213.
- Koeske, G. F., & Koeske, R. D. (1993). A preliminary test of a stress-strain-outcome model for reconceptualizing the burnout phenomenon. *Journal of Social Service Research*, *17*, 3/ 4, 107-135.
- Kumar, S., Fischer, J., Robinson, E., Hatcher, S., & Bhagat, R.N. (2007). Burnout and job satisfaction in New Zealand psychiatrists: A national study. *International Journal of Social Psychiatry*, *53*, 4, 306-316.
- \*Jayaratne, S. & Chess, W. A. (1984). Job Satisfaction, Burnout and Turnover: A National Study. *Social Work*, *29*, 5, 448-453.
- Lee, R. T., & Ashforth, B. E. (1996). A meta-analytic examination of the correlates of the three dimensions of job burnout. *Journal of Applied Psychology*, *81*, 2, 123-133.
- Leiter, M. P. (1988). Burnout as a function of communication patterns. *Group & Organization Studies*, *13*, 111-128.
- Leiter, M. P. & Maslach, C. (1988). The impact of interpersonal environment on burnout and organizational commitment. *Journal of Organizational Behaviour*, *9*, 297-308.
- Leiter, M. P. & Meechan, K. (1986). Role structure and burnout in the field of human services. *Journal of Applied Behavioral Science*, *22*, 47-52.

- Leiter, M. P., & Schaufeli, W. (1996). Consistency of the burnout construct across occupations. *Anxiety, Stress, and Coping*, 9, 229-243.
- Lewin, J. & Sager, J. (2007). A burnout process model among salespeople: Some new thoughts. *Journal of Business Research*, 60, 1216-1224.
- Lloyd, C. & King, R. (2004). A survey of burnout among Australian mental Health occupational therapists and social workers. *Social Psychiatry and Psychiatric Epidemiology*, 39, 752-757.
- \*Martin, U. & Schinke, S. (1998). Organisational and individual factors influencing job satisfaction and burnout in mental health workers. *Social work in health care*, 28, 2, 51-62.
- Maslach, C. (1982). *Burnout: The cost of caring*. Englewood Cliffs, USA: Prentice Hall.
- Maslach, C., & Jackson, S.E. (1981). The measurement of experienced burnout. *Journal of Occupational Behavior*, 2, 99-113.
- Maslach, C. & Jackson, S.E. (1986). *Maslach Burnout Inventory*. (2<sup>nd</sup> Ed). Palo Alto, CA: Consulting Psychologists Press.
- Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *The Maslach Burnout Inventory* (3rd ed.). Palo Alto, CA: Consulting Psychologists Press.
- Maslach, C., & Goldberg, J. (1998). Prevention of burnout: New perspectives. *Applied and Preventive Psychology*, 7, 63-74.
- Melchior, M. E. W., Bouurs, G. J. J., Schmitz, P. & Wittich, Y. (1997). Burnout in psychiatric nursing: a meta analysis of related variables. *Journal of Psychiatric and Mental Health Nursing*, 4, 193-201.
- Morse, G., Salyers, M., Rollins, A., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its



remediation. *Administrative Policy in Mental Health and Mental Health Services Research*, 39, 341–352.

\*Nelson, T., Johnson, S. & Bebbington, P. (2009). Satisfaction and burnout among staff of crisis resolution, assertive outreach and community mental health teams. A multicentre cross sectional survey. *Social Psychiatry and Psychiatric Epidemiology*, 44, 541–549.

Ohaeri, J.U., 2003. The burden of care giving in families with a mental illness: a review of 2002. *Current Opinion in Psychiatry* 16, 457–465.

\*Olivers, N. & Kuipers, E. (1996). Stress and its relationship to expressed emotion in community mental health workers. *International journal of social psychiatry*, 42, 2, 150-159.

Onyett, S. Pillinger, T. & Muijjen, M. (1995). Job satisfaction and burnout among members of community mental health teams. *Journal of Mental Health*, 6, 1, 55-66.

\*Onyett, S., Pillinger, T. & Muijen, M. (1997). Job satisfaction and burnout amongst members of community mental health teams. *The Journal of Mental Health*, 6, 55-66.

Onyett, S. (2011). Revisiting job satisfaction and burnout in community mental health teams. *Journal of Mental Health*, 20, 2, 198-209.

Paris, M. & Hoge, M. A. (2009). Burnout in the Mental Health Workforce: A Review. *Journal of Behavioural Health Services & Research*, 37, 4, 519-528.

Pines, A. (2005). The burnout measure, short version. *International Journal of Stress Management*, 12(1), 78–88.

Priebe, S., Fakhoury, W., White, I., Watts, J., Bebbington, P., Billings, J. et al. (2004).

Characteristics of teams, staff and patients: associations with outcomes of patients in assertive outreach. *British Journal of Psychiatry*, 185, 306–11.

\*Priebe, S., Fakhoury, W. K. H., Hoffman, K. & Powell, R. A. (2005). Morale and job perception of community mental health professionals in Berlin and London. *Social Psychiatry and Psychiatric Epidemiology*, 40, 223-232.

Prosser D. (1996). Mental health, burnout and job satisfaction among hospital and community-based mental health staff. *British Journal of Psychiatry*, 169, 3, 328-337.

\*Prosser, D., Johnson, S., Kuipers, E., Dunn, G., Szmukler, G., Reid, Y. et al. (1999). Mental health, “burnout” and job satisfaction in a longitudinal study of mental health staff. *Social Psychiatry and Psychiatric Epidemiology*, 34, 295-300.

Rohland, B. M. (2000). A survey of burnout among mental health center directors in a rural state. *Administration and Policy in Mental Health*, 27, 4, 221–237.

Rossi, A., Cetranon, G., Pertile, R., Rabbi, L., Donisi, V., Grigoletti, L. et al. (2012). Burnout, compassion fatigue, and compassion satisfaction among staff in community-based mental health services. *Psychiatry Research*, 200, 933–938.

Sainsbury Centre for Mental Health. (2001). *Finding and Keeping: Review of Recruitment and Retention in the Mental Health Workforce*. The Sainsbury Centre. Retrieved from [http://www.centreformentalhealth.org.uk/pdfs/finding\\_and\\_keeping.pdf](http://www.centreformentalhealth.org.uk/pdfs/finding_and_keeping.pdf).

\*Salyers, M. P. & Bond, G. R. (2001). An Exploratory Analysis of Racial Factors in Staff Burnout Among Assertive Community Treatment Workers. *Community Mental Health Journal*, 37, 5, 393-404.

- Schaufeli, W. B., Enzmann, D., & Girault, N. (1993). Measurement of burnout: A review. In W. Schaufeli & C. Maslach & T. Marek (Eds.), *Professional burnout: Recent developments in theory and research* (pp. 199-215). Washington: Taylor & Francis.
- \*Schulz, R., Greenley, J., R. & Brown, R. (1995). Organisation, management and Client Effects on Staff Burnout. *Journal of Health and Social Behaviour*, 36, 4, 333-345.
- Schulz, R., Newsom, J., Mittelmark, M., Burton, L., Hirsch, C. & Jackson, S. (1997). Health effects of care giving: the caregiver health effects study: an ancillary study of the cardiovascular health study. *Annals of Behavioral Medicine* 19, 110-116.
- Sherring, S. & Knight, D. (2009). An exploration of burnout among city mental health nurses. *British Journal of Nursing*, 18, 20, 1234-1240.
- Snibbe JR, Radcliffe T, Weisberger C, Richards M. & Kelly J. (1989). Burnout among primary care physicians and mental health professionals in a managed health care setting. *Psychological Reports*, 65, 775-80.
- Soderfeldt, B., Soderfeldt, M., Jones, K., O'Campo, P., Muntaner, C., Ohlson, C.G., & Warg, L.-E. (1997). Does organization matter: A multilevel analysis of the demand-control model applied to human services. *Social Science and Medicine*, 44, 4, 527-534.
- Stalker, C., & Harvey, C. (2002). *Professional burnout: A review of theory, research and prevention partnerships for children and families project*. Brantford: Wilfrid Laurier University. Retrieved from [https://www.wlu.ca/documents/7177/Professional\\_burnout.pdf](https://www.wlu.ca/documents/7177/Professional_burnout.pdf)

- Thomsen, S, Soares, J, Nolan, P, Dallender, J. & Arnetz, B. (1999). Feelings of professional fulfilment and exhaustion in mental health personnel: the importance of organisational and individual factors. *Psychotherapy and Psychosomatics* 68, 157–64.
- Von Elm, E., Altman, D.G., Egger, M., Pocock, S.J., Gotsche, PC. & Vandembroucke, J.P. (2008). The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) Statement: guidelines for reporting observational studies. *Journal of Clinical Epidemiology*, 61 (4), 344-349. Retrieved from [http://www.strobe-statement.org/fileadmin/Strobe/uploads/checklists/STROBE\\_checklist\\_v4\\_cross-sectional.pdf](http://www.strobe-statement.org/fileadmin/Strobe/uploads/checklists/STROBE_checklist_v4_cross-sectional.pdf)
- \*Walsh, B. & Walsh, S. (2002). Caseload factors and the psychological well-being of community mental health staff. *Journal of Mental Health*, 11, 1, 67-78.
- \*Webster, L. & Hackett, R. K. (1999). Burnout and leadership in community mental health systems. *Administrations and Policy in mental Health*, 26, 6, 387-399.
- Weller, M. (1993). Where we came from: Recent history of community provision. In M. Weller & M. Muijen (Eds.), *Dimensions of community mental health care*. London, UK: W.B. Saunders.
- \*Wykes, T., Stevens, W. & Everitt, B. (1997). Stress in community care teams: will it affect the sustainability of community care? *Social Psychiatry and Psychiatric Epidemiology*, 32, 398-407.

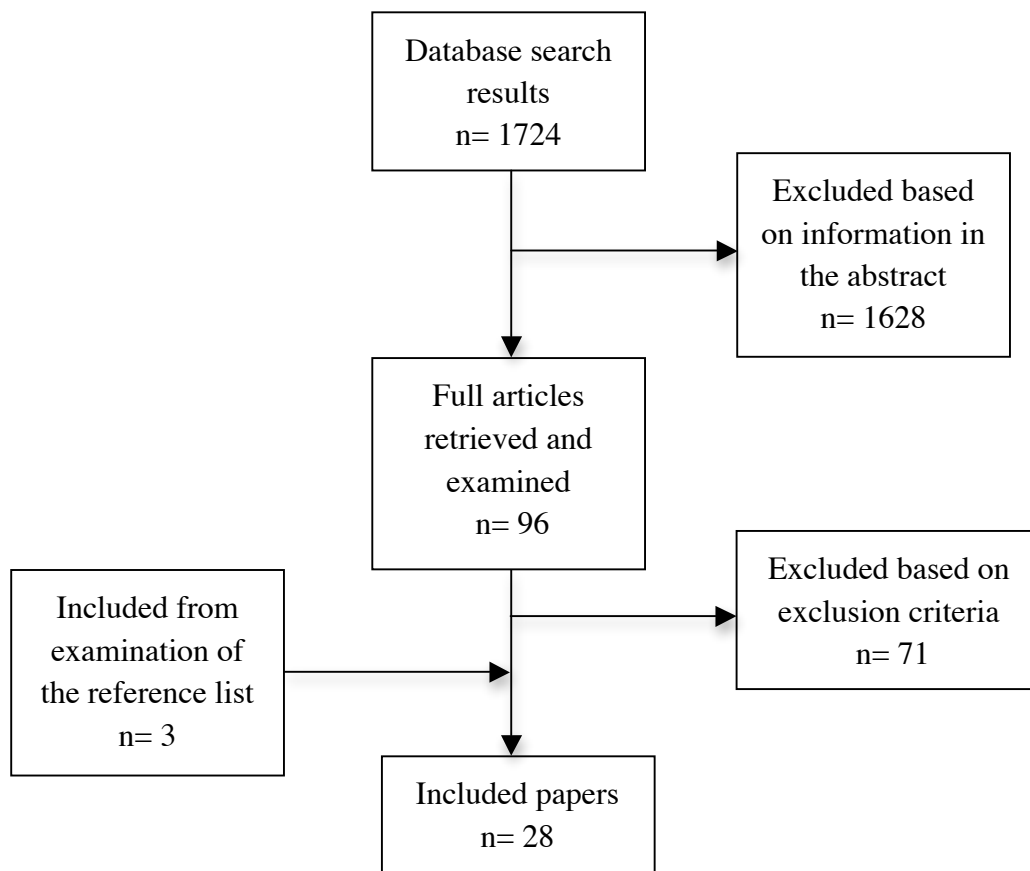


Figure 1: Flowchart of the selection process

## Appendices

### Appendix 1-A

#### Author Guidelines for The Journal of Mental Health

##### Instructions for Authors

Journal of Mental Health is an international journal adhering to the highest standards of anonymous, double-blind peer-review. The journal welcomes original contributions with relevance to mental health research from all parts of the world. Papers are accepted on the understanding that their contents have not previously been published or submitted elsewhere for publication in print or electronic form.

##### Submissions

All submissions, including book reviews, should be made online at Journal of Mental Health's Manuscript Central site at <http://mc.manuscriptcentral.com/cjmh> . New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting. Authors will be asked to add this information in section 4 of the on-line submission process.

The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count.

Manuscripts will be dealt with by the Executive Editor, Professor Til Wykes, Department of Psychology, Institute of Psychiatry, De Crespigny Park, London, SE5 8AF, United Kingdom. It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process. The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing.

Book Reviews. All books for reviewing should be sent directly to Martin Guha, Book Reviews Editor, Information Services & Systems, Institute of Psychiatry, KCL, De Crespigny Park, PO Box 18, London, SE5 8AF.

Manuscripts should be typed double-spaced (including references), with margins of at least 2.5cm (1 inch). The cover page (uploaded separately from the main manuscript) should show the full title of the paper, a short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names, the exact word length of the paper and affiliations of authors and the address where the work was carried out. The corresponding author should be identified, giving full postal address, telephone, fax number and email address if available. To expedite blind reviewing, no other pages in the manuscript should identify the authors. All pages should be numbered.

Abstracts. The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The

declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content.

#### Keywords

Authors will be asked to submit key words with their article, one taken from the picklist provided to specify subject of study, and at least one other of their own choice. Text. Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Key Words, Main text, Appendix, References, Figures, Tables. Footnotes should be avoided where possible. The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count. Language should be in the style of the APA (see Publication Manual of the American Psychological Association, Fifth Edition, 2001).

Style and References. Manuscripts should be carefully prepared using the aforementioned Publication Manual of the American Psychological Association , and all references listed must be mentioned in the text. Within the text references should be indicated by the author's name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes et al ., 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by author (showing the names of all authors), in the following standard forms, capitalisation and punctuation:

a) For journal articles (titles of journals should not be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. *Magnetic Resonance Imaging*, 18 , 351–355.

b) For books:

Powell, T.J. & Enright, S.J. (1990) *Anxiety and Stress management* . London: Routledge

c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In G.Parry & F. Watts (Eds.), *A Handbook of Skills and Methods in Mental Health Research* (pp. 75–89). London:Lawrence Erlbaum.

Illustrations should not be inserted in the text. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in

Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate page, or caption should be entered where prompted on submission, and should make interpretation possible without reference to the text. Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied. Tables should be typed on separate pages and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should not be used.

#### Accepted papers

If the article is accepted, authors are requested to submit their final and revised version of their manuscript on disk. The disk should contain the paper saved in Microsoft Word, rich text format (RTF), or as a text or ASCII (plain) text file. The disk should be clearly labelled with the names of the author(s), title, filenames and software used. Figures should be included on the disk, in Microsoft Excel. A good quality hard copy is also required.

Proofs are supplied for checking and making essential corrections, not for general revision or alteration. Proofs should be corrected and returned within three days of receipt. Early Electronic Offprints. Corresponding authors can now receive their article by e-mail as a complete PDF. This allows the author to print up to 50 copies, free of charge, and disseminate them to colleagues. In many cases this facility will be available up to two weeks prior to publication. Or, alternatively, corresponding authors will receive the traditional 50 offprints. A copy of the journal will be sent by post to all corresponding authors after publication. Additional copies of the journal can be purchased at the author's preferential rate of £15.00/\$25.00 per copy.

Copyright. It is a condition of publication that authors transfer copyright of their articles, including abstracts, to Shadowfax Publishing and Informa Healthcare. Transfer of copyright enables the publishers to ensure full copyright protection and to disseminate the article and journal to the widest possible readership in print and electronic forms. Authors may, of course, use their article and abstract elsewhere after publication providing that prior permission is obtained from Taylor and Francis Ltd. Authors are themselves responsible for obtaining permission to reproduce copyright material from other sources.



## Appendix 1-B

## STROBE Statement (Von Elm et al., 2008).

Checklist of items that should be included in reports of cross sectional studies.

**Title and abstract**

1. a) Indicate the study's design with a commonly used term in the title or the abstract
- b) Provide in the abstract an informative and balanced summary of what was done and what was found

**Introduction**

Background/rationale

2. Explain the scientific background and rationale for the investigation being reported

Objectives

3. State specific objectives, including and pre-specified hypotheses

**Method**

Study design

4. Present key elements of study design early in the paper

Setting

5. Describe the setting, locations and relevant dates, including periods of recruitment, exposure, follow-up and data collection

Participants

6. Give the eligibility criteria and the sources and methods of selection of participants

Variables

7. Clearly define all outcomes, exposures, predictors, potential confounders and effect modifiers. Give diagnostic criteria, if applicable

Data sources/management

8. For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe Comparability of assessment methods if there is more than one group

Bias

9. Describe any efforts to address potential sources of bias

Study size

10. Explain how the study size was arrived at

Quantitative variables

11. Explain how quantitative variables were handled in the analysis. If applicable, describe which groupings were chosen and why

Statistical methods

12. a) Describe all statistical methods, including those used to control for confounding
- b) Describe any methods used to examine subgroups and interactions
- c) Explain how missing data were addressed
- d) If applicable, describe analytic methods, taking account of sampling strategy
- e) Describe any sensitivity analysis

## **Results**

### Participants

13. a) Report numbers of individual at each stage of study – e.g. numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed
- b) Give reasons for non participation at each stage
- c) Consider use of flow diagram

### Descriptive data

14. a) Give characteristics of study participants (e.g. demographic, clinical, social) and information on exposures and potential confounders
- b) Indicate number of participants with missing data for each variable of interest

### Outcome data

15. Report numbers of outcome events or summary measures

### Main results

16. a) Give unadjusted estimates and if applicable, confounder-adjusted estimates and their precision (e.g., 95% confidence intervals). Make clear which confounders are adjusted for and why they were included.
- b) Report category boundaries when continuous variables were categorized
- c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period

### Other analyses

17. Report other analyses done – e.g. analyses of subgroups and interactions and sensitivity analyses.

## **Discussion**

### Key results

18. Summarise key results with reference to study objectives

### Limitations

19. Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias

### Interpretation

20. Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies and other relevant evidence

### Generalisability

21. Discuss the generalisability (external validity) of the study results

## **Other Information**

Funding

22. Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based.

## Appendix 1-C

## Quality Assessment Criteria.

*Introduction*

1. The rationale and aims of the study were clearly explained.

*Method*

2. Study reported adequate information on the recruitment strategy, including explicitly describing what mental health services were utilised, how many participants were approached, how many took part and how many dropped out (where studies were longitudinal in methodology).
3. Study reported a breakdown of the professional background of participants and did not include admin or secretarial staff in the sample.
4. The inclusion and exclusion criteria were explicitly stated.
5. Discussed issues of power and/or effect size in the method.
6. Commented on the reliability and/or validity of the chosen measures of burnout and related variables, or at least discussed the internal consistency for this sample.

*Results*

7. Adequately reported staff demographic information.
8. Reported descriptive information for all measures of burnout and other variables of interest, including means.
9. The analysis of the data was coherent and adequately explained.
10. Discusses how missing data was managed.

## Appendix 1-D

Description of the studies included.

Reference & Study ID	Location	Sample	Measures	Analysis	Main Findings	QAS <sup>1</sup>
1. Blau et al (2013)	USA	1639 psychiatric rehabilitation practitioners	MBI (Maslach & Jackson, 1982) Personal Involvement (own measure)	Correlation (type not stated)  Step wise regression	EE: age ( $r=-.08$ , $p<0.05$ ), length of service ( $r=-0.07$ , $p<0.05$ ), personal involvement ( $r=0.12$ , $p<0.01$ ). DP: age ( $r=-0.10$ , $p<0.01$ ), length of service ( $r=-0.08$ , $p<0.05$ ), personal involvement ( $r=0.14$ , $p<0.01$ ). PA: age ( $r=-0.18$ , $p<0.01$ ), length of service ( $r=-0.15$ , $p<0.01$ ). EE: Education ( $\beta=0.08$ , $p<0.05$ ), personal involvement ( $\beta=0.10$ , $p<0.01$ ). DP: Female gender ( $\beta=0.20$ , $p<0.01$ ), age ( $\beta=0.05$ , $p<0.05$ ), personal involvement ( $\beta=0.05$ , $p<0.01$ ). PA: age ( $\beta=0.04$ , $p<0.05$ ), length of service ( $\beta=0.05$ , $p<0.05$ ).	5
2. Acker (2011)	USA	460 mental health service	MBI (Maslach, Jackson & Leiter, 1996).	Correlation (type not stated)	EE: intent to quit ( $r=0.32$ , $p<0.01$ ), Clients with MI ( $r=0.25$ , $p<0.01$ ),	6

<sup>1</sup>QAS: Quality Assessment Criteria

MBI: Maslach Burnout Inventory. RCAS: Role Conflict and Abiguity Scale. SPC: Self perceived competence. MJSS: Minesota Job Satisfaction Scale. CMHT: Community Mental Health Team. MCCS: Manchester Clinical Supervision Scale. GHQ: General Health Questionnaire. BAI: Beck Anxiety Inventory. WES: Work Environment Scale.

		providers	RCAS (Rizzo, House & Lirtzman, 1970). Involvement with clients (Hagen & Hutchinson, 88) Workplace Support Scale (Caplan et al, 1980) Intention to quit scale (Lichtenstein, Alexandar, Mccarty & Wells, 1980)	Heirarchial Regression	workplace support ( $r=-0.30$ , $p<0.01$ ), Opportunities for professional development ( $r=-0.21$ , $p<0.01$ ), type of funding ( $r=-0.26$ , $p<0.01$ ), level of education ( $r=0.21$ , $p<0.01$ ). Role stress ( $\beta=0.367$ , $p<0.01$ ) predictor of EE.	
3. Acker & Lawrence (2009)	USA	140 mental health professionals	MBI (Maslach & Jackson, 1986). Adapted version RCAS (Rizzo et al, 1970). Modified version of SPC (Hall & Keefe, 2000) Involvement with clients (Hagen & Hutchinson, 88) Adapted Workplace Support Scale (Caplan et al, 1980)	Pearson's correlation  Heirarchial regression	EE: perceieved competence ( $r=-0.52$ , $p<0.01$ ), role stress ( $r=0.30$ , $p<0.01$ ), involvement with clients with SMI ( $r=-0.36$ , $p<0.01$ ), social support ( $r=-0.26$ , $p<0.05$ ), family status ( $r=-0.37$ , $p<0.01$ ). Competence ( $\beta=0.533$ , $p<0.01$ ) predictor of EE.	5
4. Priebe et al. (2005)	Germany & UK	189 CMHT professionals	MBI (Maslach & Jackson, 1981, 1996) The Team Identity Scale (Rizzo et al., 1970) The MJSS (Weiss et al., 1967)	ANOVA  GLM Univariate test	EE: Location of team & job role ( $F=5.96$ , $p<0.001$ ). DP: Location of team & job role ( $F=33.24$ , $p<0.001$ ) Professional group significant predictor of burnout ( $F=20.72$ [2], $p<0.001$ ). Interaction effect stating difference between professional group depends on location ( $F=4.43$ [2], $p<0.05$ ). Being a social worker significant	6

				Stepwise Multiple regression	predictor of higher burnout ( $\beta=0.22$ , $t = 3.19$ , $p<0.01$ , $r^2=5.7$ ) and being male was a predictor of lower burnout ( $\beta=-0.17$ , $t = 2.50$ , $p<0.05$ , $r^2=2.5$ )	
5. Crawford et al. (2010)	UK	118 staff employed in personality disorder services	MBI (Maslach & Jackson, 1996).	T test	EE ( $t=2.5$ , $p<0.01$ ), DP ( $t=2.5$ , $p<0.01$ ) lower & PA higher ( $t=3.4$ , $p<0.01$ ) in staff working in PD services.	6
6. Nelson et al. (2008)	UK	132 staff employed in crisis resolution services	MBI (Maslach & Jackson, 1986). The MJSS (Weiss et al., 1967) The Job Diagnostic Survey (Hackman & Oldham, 1975) PLAO questionnaire (Billings et al., 2003)	Exploratory regression analysis	EE: Lower in Asian ethnic group ( $\beta=-5.5$ , $p<0.01$ ), longer length of service ( $\beta=-0.2$ , $p<0.05$ ). DP: Lower in ethnic minority group ( $\beta=-1.9$ , $p<0.01$ ), longer length of service ( $\beta=-0.1$ , $p<0.05$ ), females Lower in Asian ethnic group ( $\beta=-5.5$ , $p<0.01$ ), longer length of service ( $\beta=-1.3$ , $p<0.01$ ), psychologist ( $\beta=-12.6$ , $p<0.05$ ), aged over 55 ( $\beta=-4.7$ , $p<0.01$ ), aged 46-54 ( $\beta=-3.3$ , $p<0.05$ ), CMHT member ( $\beta=1.8$ , $p<0.01$ ), black ethnic group	6
7. Acker (2008)	USA	460 mental health service providers	MBI (Maslach & Jackson, 1986). Adapted version RCAS (Rizzo et al, 1970). Intention to quit (Alexander, McCarty & Wells, 2004)	Correlation (type not stated)	EE: role stress ( $r=0.47$ , $p<0.01$ ), Intention to quit ( $r=0.32$ , $p<0.01$ ), race ( $r=0.19$ , $p<0.01$ ), education ( $r=0.21$ , $p<0.01$ ), funding ( $r=-0.26$ , $p<0.01$ ), salary ( $r=-0.24$ , $p<0.01$ ), number of children ( $r=0.08$ , ns), marital status ( $r=0.05$ , ns), age ( $r=0.04$ , ns), experience ( $r=0.03$ , ns), type ( $r=0.10$ , ns), size ( $r=0.04$ , ns), caseload ( $r=0.06$ , ns).	6

				Heirarchial multiple regression	<p>DP: role stress (<math>r=0.29</math>, <math>p&lt;0.01</math>), Intention to quit (<math>r=0.17</math>, <math>p&lt;0.05</math>), race (<math>r=0.09</math>, ns), age (<math>r=-0.21</math>, <math>p&lt;0.01</math>), education (<math>r=0.11</math>, ns), funding (<math>r=0.03</math>, ns), salary (<math>r=-0.06</math>, ns), number of children (<math>r=-0.10</math>, ns), marital status (<math>r=-0.04</math>, ns), experience (<math>r=-0.08</math>, ns), type (<math>r=0.09</math>, ns), size (<math>r=0.05</math>, ns), caseload (<math>r=-0.06</math>, ns).</p> <p>PA: role stress (<math>r=-0.10</math>, ns), intention to quit (<math>r=-0.26</math>, <math>p&lt;0.01</math>), race (<math>r=0.13</math>, <math>p&lt;0.05</math>), age (<math>r=0.26</math>, <math>p&lt;0.01</math>), education (<math>r=0.08</math>, ns), funding (<math>r=-0.04</math>, ns), salary (<math>r=-0.02</math>, ns), number of children (<math>r=-0.09</math>, ns), marital status (<math>r=-0.03</math>, ns), experience (<math>r=-0.19</math>, <math>p&lt;0.05</math>), type (<math>r=-0.08</math>, ns), size (<math>r=0.04</math>, ns), caseload (<math>r=-0.09</math>, ns).</p> <p>EE: Socio-demographic did not predict (<math>R^2=.08</math>, <math>F(7,430)=1.43</math>, <math>p&lt;.201</math>) but agencies variables did (<math>R^2=.02</math>, <math>F(2,424)=2.36</math>, <math>p&lt;.003</math>).</p> <p>DP: Socio-demographic predicted (<math>R^2=.092</math>, <math>F(7,432)=3.04</math>, <math>p&lt;.033</math>). Does not report remaining insignificant results.</p> <p>PA: Socio-demographic predicted (<math>R^2=.12</math>, <math>F(7,431)=4.00</math>, <math>p&lt;.001</math>).</p>	
8. Edwards et al. (2005)	UK	260 community	MBI (Maslach & Jackson, 1986).	Non parametrics for group	<p>EE: total MCSS score (<math>r=-0.148</math>, <math>p&lt;0.05</math>)</p> <p>DP: total MCSS score (<math>r=-0.220</math>, <math>p&lt;0.01</math>),</p>	6



		mental health nurses	MCSS (Winstanley, 2000)	comparisons Pearsons correlations	experience of 6 sessions of supervision (z=-2.935 p<0.01), age (r=-0.190, p<0.01), gender (z=-3.583, p<0.01).	
9. Evans et al. (2006)	UK	462 social workers	MBI (Maslach & Jackson, 1986). GHQ (Goldberg, 1992) Job satisfaction- single item (Andrews & Withney, 1976)	ANOVA  Linear regression	EE: decision latitude (F=5.00, (2, 221), p<0.01), job demand (F=25.44, (2, 219), p<0.01), social support (F=5.53, (2, 223), p<0.01). DP: decision latitude (F=3.20, (2, 221), p<0.05), job demand (F=1.53, (2, 219), ns), social support (F=1.64, (2, 223), ns). PA: decision latitude (F=11.56, (2, 217), p<0.01), job demand (F=1.76, (2, 216), ns), social support (F=0.22, (2, 221), ns). EE: job demands, feeling valued & feelings about the social work role (R <sup>2</sup> =0.30, F=5.45 [17], p<0.001). DP: Feelings about social work role, feeling valued, gender (R <sup>2</sup> =0.15, F=2.86 [17], p<0.001). PA: decision latitude (R <sup>2</sup> =0.06, F=1.61 [17], ns).	5
10. Galazzi et al (2004)	Italy	30 psychiatrists & 30 community psychiatric nurses	MBI (Maslach & Jackson, 1981) The Team Identity Scale (Rizzo et al., 1970) The MJSS (Weiss et al., 1967)	ANOVA  Pearson's Correlation	EE: Psychiatrists scored higher than nurses (F=7.59, (1, 56), p<0.01). DP: Psychiatrists scored higher than nurses (F=4.46, (1, 56), p<0.05), marginally significant. PA No difference between staff groups (F=1.00, (1, 54), ns), EE: age (r=0.33, p<0.05), years employed in MH since qualifying (r=0.28, p<0.05),	7

				Stepwise Multiple Regression	no. of jobs since qualifying ( $r=0.45$ , $p<0.01$ ). DP: years employed in MH since qualifying ( $r=0.27$ , $p<0.05$ ), no. of jobs since qualifying ( $r=0.39$ , $p<0.01$ ). PA: no correlation with any demographic variable (does not report statistics). EE: psychiatrist ( $R=0.33$ , $p<0.05$ ), team conflict as pressure source ( $R=0.29$ , $p<0.05$ ). DP: high caseload ( $R=0.22$ , $p<0.05$ ), generic clinical activity ( $R^2=0.33$ , $p<0.05$ ). No relation with job satisfaction.	
11. Wykes et al (1997)	UK	61 mental health staff	MBI (Maslach & Jackson, 1986). GHQ-28 (Goldberg & Williams 1988) BAI (Beck, 1990) Daily Hassles Scale (Kanner et al, 1981; Lazarus & Folkman, 1989)	Pearson's Correlation  ANOVA	EE: GHQ ( $R=0.651$ , $p<0.001$ ), BAI ( $R=0.337$ , $p<0.01$ ), daily hassles ( $R=0.404$ , $p<0.001$ ), DP: GHQ ( $R=0.532$ , $p<0.001$ ) PA: GHQ ( $R=-0.368$ , $p<0.01$ ), BAI ( $R=0.409$ , $p<0.001$ ), turnover, ( $R=0.28$ , $p<0.05$ ). EE: ethnic minorities less EE ( $t=-4.77$ , $p<0.001$ ) DP: ethnic minorities less EE ( $t=-3.00$ , $p<0.05$ ), Inner city staff higher levels ( $t=2.19$ , $p<0.05$ ). Burnout: No main effect of sick leave, number of courses attended, job tenure or overtime and no differences between professions (results not reported). No difference if team evaluated or not (t	5



					MSE = 24.91, P=0.07) than Caucasians and Hispanics. License eligible clinicians rated themselves lower on PA (F, 4, 127 = 3.02, MSE= 25.79, P<0.05) and higher on DP (F, 4, 127 = 4.55, MSE = 22.81, P<0.01) than licensed status.	
13. Acker (1999)	USA	128 outpatient mental health social workers	MBI (Maslach & Jackson, 1982, 1986) Involvement with clients with mental illness (own measure) Job in General Scale (Ironside, Smith, Brannick, Gibon & Paul, 1989).	Pearson's Correlation  ANOVA	EE: Extent involved with clients with SMI (r=0.34, p<0.01), adequate support (r=-0.23, p<0.01) DP: Extent involved with clients with SMI (r=0.21, p<0.05). PA: Extent involved with clients with SMI (ns). DP: Type of population- adults scored higher than working with children (F [1, 126]=5.645, p<0.05).	6
14. Onyett et al., (1997)	UK	445 CMHT staff	MBI (Maslach & Jackson, 1986) Occupational Stress Indicator (Cooper, Sloan & Williams, 1988) RCAS (Rizzo, House & Lirtzman, 1970). Personal and team identification scale (Brown et al., 1986)	Pearson's Correlation	EE: team clarity (r=-0.38, p<0.001), personal role clarity (r=-0.27, p<0.001), team identification (r=-0.21, p<0.001), professional identification (r=-0.21, p<0.001), caseload size (r=0.02, ns), % seen fortnightly or more (r=0.03, ns), % severe and long term mental health problems (r=0.04, ns). DP: team clarity (r=-0.26, p<0.001), personal role clarity (r=-0.19, p<0.001), team identification (r=-0.18, p<0.001), professional identification (r=-0.18,	7

				ANOVA or Kruskal-Wallis when non-parametric needed.	<p>p&lt;0.001), caseload size (r=0.02, ns), % seen fortnightly or more (r=-0.09, ns), % severe and long term mental health problems (r=0.08, ns).</p> <p>PA: team clarity (r=0.21, p&lt;0.001), personal role clarity (r=0.17, p&lt;0.001), team identification (r=0.19, p&lt;0.001), professional identification (r=0.27, p&lt;0.001), caseload size (r=0.21, p&lt;0.001), % seen fortnightly or more (r=0.12, ns), % severe and long term mental health problems (r=0.02, ns).</p> <p>Consultant psychiatrists, social workers, nurses and psychologists were particularly emotionally exhausted (F[11, 420]=2.9, p&lt;0.001) and voluntary staff and consultant psychiatrists reported most personal accomplishment (K-WX2=32.1, p&lt;0.001). Consultant psychiatrists reported higher depersonalisation than the scale norms, in contrast to the sample as a whole (K-WX2=42.5, p&lt;0.001).</p>	
15. Salyers & Bond (2001)	USA	72 case managers in assertive outreach services	<p>MBI (Maslach &amp; Jackson, 1986)</p> <p>The WES (Moos, 1986)</p>	T tests	<p>EE: Caucasians reported higher levels of EE (t=3.46, p&lt;0.001) than African Americans, age (r=-0.30, p&lt;0.05)</p> <p>DP: Caucasians reported higher levels of DP (t=2.09, p&lt;0.05) than African Americans, age (r=-0.44, p&lt;0.001).</p> <p>PA: no difference in ethnicity (t=0.46,</p>	6

				ANCOVA	ns). ANCOVA significant when comparing Caucasians & African Americans on EE (F[2,59]=6.04, p<0.01) and DP (F[2,59]=6.74, p<0.01). Age accounted for remained significant for EE (F[1,59]=7.51, p<0.01) but not DP (F[1,59]=1.43, ns).	
16. Oliver & Kuipers (1996)	Not disclosed	10 community mental health workers	MBI (Maslach & Jackson, 1986) GHQ (Goldberg & Williams, 1988) MJSS (Koelbel et al., 1991) Breif Psychiatric Rating Scale (Overall & Gorham, 1962) Camberwell Family Interview (Vaughan & Leff, 1976)	ANOVA	Expressed emotion is not related to EE or DP (no statistics reported).	4
17. Acker (2003)	USA	259 outpatient mental health service providers	MBI (Maslach & Jackson, 1986) RCAS (Rizzo, House & Lirtzman, 1970). Workplace Support Scale (Caplan et al, 1980) Extent working with clients with severe mental	Pearson's Correlation	EE: role conflict (r=0.33, p<0.01), role ambiguity (r=0.21, p<0.01), education (r=0.14, p<0.05), support from supervisor (r=-0.15, p<0.05), support from family (r=-0.12, p<0.05), support from co-workers (r=-0.15, p<0.05), salary (r=-0.24, p<0.01), involvement (r=0.06, ns), age (r=0.01, ns), length of employment	5

			illness (Acker, 1999).	Heirarchial regression analysis	<p>(<math>r=-0.04</math>, ns), caseload (<math>r=-0.05</math>, ns), gender (<math>r=0.02</math>, ns), marital status (<math>r=0.02</math>, ns).</p> <p>DP: role conflict (<math>r=0.17</math>, <math>p&lt;0.01</math>), role ambiguity (<math>r=0.29</math>, <math>p&lt;0.01</math>), education (<math>r=0.13</math>, <math>p&lt;0.05</math>), age (<math>r=0.18</math>, <math>p&lt;0.05</math>), gender (<math>r=-0.19</math>, <math>p&lt;0.01</math>), support from supervisor (<math>r=-0.07</math>, ns), support from family (<math>r=0.11</math>, ns), support from co-workers (<math>r=-0.03</math>, ns), salary (<math>r=-0.11</math>, ns), involvement (<math>r=0.06</math>, ns), length of employment (<math>r=-0.12</math>, ns), caseload (<math>r=-0.00</math>, ns), marital status (<math>r=0.00</math>, ns).</p> <p>PA: role conflict (<math>r=0.08</math>, ns), role ambiguity (<math>r=-0.17</math>, <math>p&lt;0.01</math>), education (<math>r=0.08</math>, ns), age (<math>r=0.25</math>, <math>p&lt;0.01</math>), gender (<math>r=0.02</math>, ns), support from supervisor (<math>r=-0.11</math>, ns), support from family (<math>r=0.08</math>, ns), support from co-workers (<math>r=0.17</math>, <math>p&lt;0.01</math>), salary (<math>r=-0.04</math>, ns), involvement (<math>r=0.03</math>, ns), length of employment (<math>r=-0.20</math>, <math>p&lt;0.01</math>), caseload (<math>r=-0.04</math>, ns), marital status (<math>r=0.05</math>, ns).</p> <p>EE: 12% variance predicted by demographic variables, additional 19% accounted for by work related variables when demographic accounted for.</p> <p>DP:DP: 12% variance predicted by demographic variables, 9% accounted for</p>
--	--	--	------------------------	---------------------------------	---





					responsibilities (t=1.94, 276, p=0.054), had completed specialist post training (t=2.04, 278, p<0.05) and who drank alcohol (t=3.40, 279, p<0.001).	
19. Carson et al (1997)	UK- used Clayburn Stress Study data	568 mental health nurses (245 community & 323 ward staff)	MBI (Maslach & Jackson, date unknown) GHQ-12 (Goldberg & Williams, 1988) Modified Rosenberg Self Esteem Scale (reference not given)	Spearman's Rho Correlation	Self-esteem correlated with EE (r=0.260, p<0.001), DP (r=0.180, p<0.01), PA (r=-0.280, p<0.01).	5
20. Schulz et al (1995)	USA	311 staff in CMHT	MBI (Maslach & Jackson, 1981) Job Satisfaction Scale (Spector, 1985) Katz General Pathology Scale (Widlack et al, 1992) Work Environment (Schulz & Schulz, 1988) Transactional Scale (Bass, 1985) Activities of daily living (not valid maeasure)	A variance-covariance matrix to build a non-recursive system of linear equations	Burnout: not related to client severity & functioning, number of hospital admissions, age, professionalism, gender, job involvement (statistics not reported). Direct effect on burnout: Work satisfaction, education & job (full statistics not reported). Indirect effect on burnout: Leadership & Organisational culture & all work environment (job clarity, goal congruence, staff autonomy, participation) had an indirect effect on BO through work satisfaction, except organisation (clan) culture. Team structure indirect effect on BO through work environment variables and work satisfaction (full statistics not reported).	2
21. Prosser et	UK	Mental health	MBI (Maslach & Jackson,	Multiple	EE: nurse (R=4.03, p<0.05), social	5

al (1999)		services 121 in 1994 100 in 1995 94 in 1996	1986) GHQ-12 (Goldberg & Williams, 1988) Job Diagnostic Surevy (Hackman & Oldham, 1975)	Regression Multiple Logistic Regression	worker (R=13.32, p<0.001), very new (R=-3.24, p<0.05), very experienced (R=-4.56, p<0.05), in the sector longest in the community (R=-0.34, p<0.05). DP: nurse (R=2.34, p<0.01), white (R=3.44, p<0.001), psychologist (R=-3.22, p<0.01), experienced in job (R=-3.05, p<0.01). PA: no significant variables in the regression model (statistics not reported).	
22. Martin & Schinke (2008)	USA	98 mental health social workers	MJSS (Weiss et al., 1967) MBI (Maslach & Jackson, 1986), Staff Burnout Scale for Health Professionals (Jones, 1980).	T tests  Pearson's Correlation  Multiple Regression	Burnout: social service tenure (r=-0.08, p statistic not reported), anticipated salary (r=-0.21, p statistic not reported), salary statistics (r=-0.35, p statistic not reported), promotional satisfaction (r=-0.48, p statistic not reported), harsh criticism delivered by a supervisor (r=0.43, p statistic not reported). Praise satisfaction not correlation (r=-0.60, p statistic not reported). Burnout did not predict job satisfaction.	5
23. Haj-Yahia et al (2000)	Israel	97 mental health social workers	MBI: MBI (Maslach & Jackson, 1981) Role Conflict (Quinn & Staines, 1979) Role Ambiguity (Caplan & Jones, 1975) Work Challenge (Jayarante et al., 1984)	Pearson's Correlation  Multiple Regression	EE: role conflict (r=0.23, p<0.05), job challenge (r=-0.37, p<0.01), job autonomy (r=0.30, p<0.01), perceived service effectiveness (r=-0.28, p<0.05) & job mastery (r=-0.22, p<0.05). No correlation with workload (r=0.08), role ambiguity (r=0.13), physical environment (r=0.02), power (r=-0.06), job satisfaction	5

			<p>Physical environment &amp; job autonomy (own measures)</p> <p>Job Mastery (Pearlin &amp; Schoder, 1970)</p> <p>Job Power (Guterman &amp; Bargal, 1996)</p> <p>Job Satisfaction (single item- Jayarante &amp; Chess, 1984)</p>		<p>(<math>r=-0.17</math>), intention to leave (<math>r=-0.17</math>). DP: job challenge (<math>r=-0.22</math>, <math>p&lt;0.05</math>), perceived service effectiveness (<math>r=-0.31</math>) and job mastery (<math>r=-0.30</math>, <math>p&lt;0.05</math>). No relationship with workload (<math>r=0.17</math>), role ambiguity (<math>r=0.07</math>), role conflict (<math>r=0.12</math>), job autonomy (<math>r=-0.01</math>), physical environment (<math>r=0.18</math>), power (<math>r=-0.08</math>), job satisfaction (<math>r=0.14</math>), intention to leave (<math>r=0.11</math>).</p> <p>PA: role ambiguity (<math>r=-0.31</math>, <math>p&lt;0.05</math>), job challenge (<math>r=-0.40</math>, <math>p&lt;0.001</math>), job autonomy (<math>r=-0.20</math>, <math>p&lt;0.05</math>), power (<math>r=0.31</math>, <math>p&lt;0.01</math>), job satisfaction (<math>r=0.20</math>, <math>p&lt;0.05</math>), perceived service effectiveness (<math>r=0.35</math>, <math>p&lt;0.01</math>), job mastery (<math>r=0.39</math>, <math>p&lt;0.05</math>) and empowerment (<math>r=0.31</math>, <math>p&lt;0.05</math>). No relationship with workload (<math>r=0.04</math>), physical environment (<math>r=-0.04</math>), intention to leave (<math>r=0.09</math>).</p>	
24. Billings et al (2003)	UK	CMHT (114) & assertive outreach (187) staff	<p>MBI (Maslach &amp; Jackson, 1986)</p> <p>Job diagnostic survey (Hackaman &amp; Oldham, 1975)</p> <p>MJSS (Weis et al., 1967)</p> <p>Sources of stress adapted (Prosser, 1997)</p> <p>Views about training &amp;</p>	Linear regression	<p>EE: black ethnic group (<math>R=-6.4</math>, <math>p&lt;0.01</math>), psychiatrist (<math>R=-5.0</math>, <math>p&lt;0.05</math>), time as mental health worker (<math>R=-0.28</math>, <math>p&lt;0.05</math>), time in post (<math>R=0.62</math>, <math>p&lt;0.05</math>).</p> <p>DP: female (<math>R=-1.3</math>, <math>p&lt;0.01</math>), psychologist (<math>R=-3.2</math>, <math>p&lt;0.01</math>), black ethnic group (<math>R=-2.0</math>, <math>p&lt;0.05</math>), aged over 55 (<math>R=-8.3</math>, <math>p&lt;0.05</math>), time in post (<math>R=0.24</math>, <math>p&lt;0.05</math>), time as mental health</p>	5



				Regression	p<0.05), role ( $\beta=-0.31$ , p<0.05), % male clients ( $\beta=0.25$ , p<0.05) DP: % male clients ( $\beta=0.24$ , p<0.05), Role ( $\beta=-0.48$ , p<0.001). PA: Demand $\beta=-0.32$ , p<0.001).	
26. Boyer & Bond (1999)	USA	216 MH staff at community mental health centres	MBI (Maslach & Jackson, 1986) Job Satisfaction Survey (Spector, 1985) WES (Moos, 1986) Case Manager Survey (no reference)	Correlation (type not stated)	Burnout: age ( $r=-0.24$ , p<0.01), (for total sample & ACT but not TCM) & years in current position ( $r=0.15$ , p<0.05), caseload size ( $r=0.22$ , p<0.01) and % time spent on paperwork ( $r=-0.23$ , p<0.01). No correlation with sex ( $r=0.20$ ), race ( $r=-0.08$ ), marital status ( $r=0.01$ ), education level ( $r=-0.11$ ), yrs in MH field ( $r=0.00$ ), caseload characteristics [% clients with schizophrenia ( $r=0.11$ ), no. of times client hospitalised ( $r=0.01$ ), % homeless clients ( $r=-0.02$ ), % abuse drugs( $r=0.03$ )].	6
27. Jayarante et al (1984)	USA	144 community mental health social workers	MBI (Maslach & Jackson, 1981) Role ambiguity & conflict (Caplan et al., 1975) Work load (Jayarante & Chess, yea not given).	Standardised regression analysis	EE: role ambiguity ( $\beta=-0.23$ , p<0.05). Age ( $\beta=-0.19$ ), years MSW received ( $\beta=-0.11$ ), workload ( $\beta=0.05$ ), value conflict ( $\beta=0.15$ ), comfort ( $\beta=0.07$ ), challenge ( $\beta=0.04$ ), financial reward ( $\beta=-0.17$ ), promotion ( $\beta=-0.03$ ) role conflict	6



**Section Two: Research Paper**

The process underpinning staff's loss and maintenance of compassion towards clients  
with complex or challenging interpersonal difficulties

**Word Count: 7,695**

Rachel Wass (nee Watts)

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

**All correspondence should be sent to:**

Rachel Wass (nee Wass)

Doctorate in Clinical Psychology

Furness College

Lancaster University

Lancaster

LA1 4YT

[r.watts@lancaster.ac.uk](mailto:r.watts@lancaster.ac.uk)

Prepared for submission to: The Journal of Mental health

**Abstract**

**Background:** Working with clients with complex or challenging interpersonal difficulties can be highly stressful for staff and, at times, it can prove difficult to maintain compassion.

**Aim:** To investigate the loss and maintenance of compassion in community mental health staff.

**Method:** Eleven participants working with clients with complex or challenging interpersonal difficulties were interviewed about their experience of the loss and maintenance of compassion. A methodology drawing on constructivist grounded theory was utilised to analyse the resulting accounts.

**Results:** A sequential model was derived from the data containing four conceptual categories: adopting a compassionate stance towards others, the uphill struggle, accessing a reflective space and working within a threatening system.

**Conclusions:** Findings highlight the importance of utilising reflective practice in order to manage the difficulties faced in clinical work. The study also has clinical implications for the promotion of self-compassion among staff. Suggestions for future research are also offered.

**Keywords:** Mental Health, Staff, Compassion.



### **Introduction**

Staff working in community based mental health services support individuals with a range of complex mental health needs. Approximately 10 to 20% of clients have difficulties associated with a diagnosis of Borderline Personality Disorder (BPD). These can include difficulties with emotional regulation, maintaining positive social relationships, impulsivity and instability with regard to their self image, and are often accompanied by high levels of risk and self-harm (Leib, Zanarini, Schmahl, Linehan & Bohus, 2004; American Psychiatric Association, 2013). As such, working with this client group can be highly stressful for mental health professionals (Ohaeri, 2003).

#### **A consideration of terminology**

At least 2% of the population meet diagnostic criteria for BPD, with at least a quarter of this subset seeking help from mental health services (Krawitz & Watson, 2003). However, critics have argued a diagnosis of BPD lacks scientific validity (Boyle, 2007), is inherently stigmatizing (Mason, Caulfield, Hall & Melling, 2010) and can alter the professional's perspective and practice with regard to their client (Markman, 2003; Newton-Howes, Weaver & Tyrer, 2008; Woollaston & Hixenbaugh, 2008). Furthermore, some professionals have expressed discomfort in utilizing this diagnosis (James & Cowman, 2007) and service users themselves have commented on their aversion to this diagnostic label (Horn, Johnstone & Brooke, 2007; Kalapatapu, Patil & Goodman, 2010; Stalker, Ferguson & Barclay, 2005). Consequently, the use of the term BPD will be avoided in this paper and, instead, the author will refer to individuals with complex or challenging interpersonal difficulties as this removes the difficulties from being within the individual themselves to being interactional (i.e. relational patterns and interpersonal styles).

**Staff perceptions**

A plethora of research has considered professionals' attitudes towards clients who present with complex or challenging interpersonal difficulties. Studies suggest staff tend to hold a negative and often pejorative view of this client group (Commons Treloar & Lewis, 2008; Potter, 2006), with professional background and gender significantly contributing to the level of negativity. For example, female staff and those from an allied health professional discipline (psychology, occupational therapy and social work) report fewer negative attitudes compared to male staff and those from a medical or nursing background (Commons Treloar & Lewis, 2008). Mental health professionals show greater social distancing, rejection and negative feelings towards clients with complex or challenging interpersonal difficulties when compared with clients with other mental health difficulties (Fraser & Gallop, 1993; Markham, 2003), potentially as a consequence of transference and counter transference (Bland & Rossen, 2005). Furthermore, staff often describe clients with these difficulties as being more in control of their behaviour, compared with those with significant difficulties in mood, thus believing many displayed behaviours are deliberate attempts to gain attention (Forsyth, 2007), and as such are viewed as a disingenuous need for help (Woollaston & Hixenbaugh, 2008).

Perhaps unsurprisingly given these preconceptions, staff find this client group difficult to manage, significantly more so than clients with other mental health difficulties (Cleary, Siegfried & Walter, 2002), which could be due to the specific nature of the difficulties experienced (Ohaeri, 2003). For instance, interpersonal difficulties experienced by the client could adversely impact on interactions with staff, notably with regard to the therapeutic relationship (Stuart & Laraia, 2005), which in turn could lead to disengagement, non-adherence and powerful emotional responses

(Aviram, Brodsky & Stanley, 2006; Conklin & Westen, 2005; Kraus & Reynolds, 2001; McCready, 1987; Paris, 2005). A number of studies suggest professionals hold less optimism for change towards these clients, which could be due to a greater number of negative experiences (Markham, 2003; Markham & Trower, 2003), greater levels of frustration (Filer, 2005) or because staff feel unable to help (Woollaston & Hixenbaugh, 2008). Furthermore, it has been suggested that staff can, on occasion, display low levels of compassion and empathy to clients with complex or challenging interpersonal difficulties (Forsyth, 2007; Fraser & Gallop, 1993; Markham & Trower, 2003; Rayner et al. 2005).

### **Compassion in healthcare**

The development and use of compassion is a key component in many world religions, with Buddhism placing it at the core of its teachings and practice (Vivino, Thompson, Hill & Ladany, 2009). Compassion can be defined as:

“A basic kindness, with a deep awareness of the suffering of oneself and of other living things, coupled with a wish and effort to relieve it” (Gilbert, 2009 p. xiii).

The adoption of compassionate care has a number of benefits for clients, staff and healthcare organisations. It has been found to improve clinical outcomes, quality of life, levels of trust, treatment adherence and satisfaction of clients, as well as lowering healthcare costs and malpractice claims (Epstein et al., 2005; Haywood et al., 2010; Jackson, Chamberlain & Kroenke, 2001; Kaplan, Greenfield & Ware, 1989; Stewart, Brown & Donner, 2000; Zolnierek & Dimmateo, 2009). Peer training and support has also been shown to help build capacity for compassion in staff, preventing burnout and compassion fatigue (Lowen & Manning, 2010; Meier, Back & Morrison, 2001). Compassion of healthcare staff is currently a topic of great interest and a number of

sources have raised concern about the levels of compassion present in healthcare systems worldwide (e.g. Care Quality Commission, 2011; Crawford, 2011; Darzi, 2008; Nauert, 2011).

Given the combination of high stress levels, the personal perspectives many professionals hold in relation to this client group and the specific difficulties experienced when working with them, it is not surprising that difficulties in maintaining compassion can occur (Ohaeri, 2003; Woollaston & Hixenbaugh, 2008; Forsyth, 2007; Fraser & Gallop, 1993; Markham & Trower, 2003; Rayner et al. 2005). Interestingly, Brody and Farber (1996) found clinicians' responses to clinical vignettes differed according to the presentation described; when presented with a vignette describing a client with low mood clinicians report responses of empathy, whereas those vignettes describing a 'BPD' presentation elicited feelings of anger and irritation. Furthermore, preliminary evidence suggests self-compassion, teamwork, sense of self, insight and self care may promote resilience and play a role in helping staff to maintain compassion when working with complex clients (Edward, 2005; Rivers, 2012). Higher levels of self-compassion may also decrease levels of stress, anxiety and depression (MacBeth & Gumley, 2012).

As well as personal perceptions, systemic pressures may impact on a professional's ability to be compassionate. Crawford, Gilbert, Gilbert, Gale and Harvery (2013) completed a discourse analysis on the compassionate language used in the narratives of inpatient mental health professionals. They noted the predominant replacement of compassionate language with discussions around time, resources, heightened threat and emotional distancing, despite the interview schedule focusing on compassionate practice. Such responses suggest the impact of contextual and systemic pressures on staff's ability to maintain compassion towards clients

(Crawford et al., 2013).

### **Rationale for the current study**

In summary, compassionate healthcare has a number of benefits for service users, staff and organizations alike (Epstein et al., 2005; Haywood et al., 2010; Jackson et al. 2001; Stewart et al., 2000). However, working with clients with complex or challenging interpersonal difficulties can be stressful for staff and is often accompanied by high levels of frustration and reduced levels of compassion (Ohaeri, 2003; Filer, 2005; Brody & Farber, 1996; Forsyth, 2007). While preliminary research has documented this reduction, it has not explored the process of maintaining and/or losing compassion in mental health staff. Qualitative research permits a more in depth exploration of experiences which can further understanding of the complex interplay of factors within a specific context (Sofaer, 1999). Hence, this study seeks to investigate the process underpinning staff's loss and maintenance of compassion towards clients with complex or challenging interpersonal difficulties.

## **Method**

### **Design**

A qualitative approach was adopted as this methodology allows researchers to gather rich data that seek to understand “the context of the events as well as the events themselves” (Sofaer, 1999, p. 1102). A methodology and analysis strategy drawing upon grounded theory, as described by Charmaz (2006), was employed.

Grounded theory is concerned with the “discovery of theory from data” (Glaser & Strauss, 1967, p. 1) and offers “systematic guidelines for gathering, synthesizing, analysing and conceptualising qualitative data” (Charmaz, 2007, p. 82). This methodology utilises an inductive approach to research that encourages

researchers to consider the meaning and action behind participants' words. The researcher adopted a social constructivist epistemological stance, advocated by Charmaz (2006), which assumes there is a subjective 'truth' constructed through the language and interactions of individuals. Consequently, this approach assumes the researcher will have an active relationship with the data and their own views and experiences will direct the interpretations made (Charmaz, 2006). Thus, in order to ensure credibility, reflexivity is essential and is described in greater detail later in this methodology section.

### **Sampling and Participants**

Health professionals from a social work, mental health nursing or occupational therapy background currently working within a community mental health team or specialist personality disorder service were eligible to participate in this study.

Participants were required to have worked for at least two years with clients with complex or challenging interpersonal difficulties (a specific diagnosis of BPD was not required) and be willing to discuss fluctuations in compassion towards their clients. They also had to provide written consent, speak English and be based within the north west region of the UK.

Twenty-nine staff members expressed an interest in participating in the study, of whom 18 did not meet the above inclusion criteria. The demographic information for the 11 participants is described in appendix 2-B.

### **Recruitment Procedures**

Six community mental health teams and one specialist personality disorder service were approached about the project. In order to facilitate recruitment, team leaders, previously established contacts, or the researcher distributed information about the study. Depending on the preference of the team, information was either

distributed via email, with the participant information sheet attached, or by presenting the project at team meetings. Attendees at a recent conference, hosted by the lead trust, were also emailed on behalf of the researcher. Health professionals interested in participating in the project were asked to contact the researcher via email or telephone to discuss the project further. At this point the researcher answered any questions and screened for eligibility. If potential participants agreed to take part in the project the researcher arranged to meet with them at a convenient time.

### **Interview Schedule and Procedure**

An initial semi-structured interview schedule was developed to guide discussion. The interview schedule focused on questions around working with clients with challenging or complex interpersonal difficulties and asked participants to recall times when they had experienced fluctuations in compassion. Participants were encouraged to reflect on their experiences before and after these fluctuations, focusing on their thoughts, feelings and behaviours. The interview schedule evolved in response to the emerging analysis (see data analysis section). Participants were asked to provide demographic information and sign a consent form allowing the researcher to audio record the semi-structured interview. Interviews ranged from 43 minutes to 80 minutes and were conducted at participants' place of work as requested. All research documents can be found in the Ethics Section.

### **Data Analysis**

All 11 interviews were transcribed verbatim by the author and any identifiable information was removed. Participants were also assigned pseudonyms to protect anonymity. In line with Charmazian constructivist grounded theory methodology (2006), transcripts were then analysed utilising two levels of coding; initial line by line coding and focused coding (see appendix 2-C). Initial codes were assigned to

each line of the transcript using gerunds to summarise content and begin to identify meaning. These initial codes were then organised into focused codes given their significance and ability to explain large segments of data. Focused codes then informed sub-categories and conceptual categories (see appendix 2-D), and a model was derived to depict the relationship between these. During the analytic process new data were compared with pre-existing codes and data, in accordance with the constant comparative method (Charmaz, 2006; Glaser & Strauss, 1967), and adaptations were made accordingly. Throughout the data collection and analytic process memos were written to inform the development of conceptual categories and document reflections about key processes within the emerging theory (see appendix 2-E). The use of memos extends the researcher's thinking about generated categories and helps to build a narrative around these, as well as directing analysis during coding (Charmaz, 2007).

Grounded theory is distinct to other qualitative methodology as it encourages the researcher to conduct data collection and analysis simultaneously (Birks & Mills, 2011). Commonly known as theoretical sampling (Charmaz, 2006) this enables future data collection to develop areas of interest and to explore inconsistencies and uncertainties within the data set in order to refine emerging categories. Theoretical sampling encourages the researcher to amend the interview schedule according to the emerging theory (Charmaz, 2006). Changes within this project included the addition of questions pertaining to the utilisation of colleagues and the influence of personal values.

Pure grounded theorists advocate the continuation of data collection until saturation (Glaser & Strauss, 1967). However, this is often unrealistic, specifically within health research and those adhering to a given timescale. Thus, the pragmatic



approach of data sufficiency rather than saturation was utilised, which suggests researchers should stop data collection when categories are sufficiently explored (Dey, 1999).

### **Credibility of Analysis**

Observing and acknowledging one's own position in relation to the research is an important consideration for credibility, as well as for the analytic process (Elliot, Fischer & Rennie, 1999; Charmaz, 2006). Furthermore, transparency about the values, beliefs and ideas held by the researcher allows the reader to understand the researcher's position and interpret the data presented (Elliot et al., 1999). Therefore, the researcher reflected on both personal and professional perspectives throughout the research process, enhancing credibility by writing memos and keeping a reflective journal (Ortlip, 2008) that documented personal reflections and decision-making moments throughout the research process. As recommended by Yardley (2008), further attempts to ensure credibility comprised providing descriptive data about the participants (e.g. age, gender), showing transparency in the analysis by providing coding examples, and including a diagrammatic representation of the ensuing model for coherence to increase confidence in the findings. With regard to the latter, the researcher's academic supervisor read participants' transcripts and both academic and field supervisors were consulted on analytic decisions about the ensuing model at various points, offering feedback. Finally, the researcher attended a grounded theory methodology peer group to discuss the analytic process and reflect on the credibility.

### **Results**

Using the above analysis strategy, a sequential model was constructed which explains how staff's compassion towards their clients fluctuated (see Figure 1). Figure

one should be considered in conjunction with the following narrative, which together illustrate the relationship between the conceptual categories and their constituent sub-categories.

Four conceptual categories were constructed from the data: adopting a compassionate stance towards others, the uphill struggle, accessing a reflective space, which sits within a culture of compassion, and working within a threatening system. The first category depicts the adoption of a compassionate stance, which includes its relationship with participants' values and in challenging their preconceptions. Category two refers to the challenges faced by participants, which threatened their compassionate stance and how they became aware of diminishing compassion in the face of these challenges. Accessing a reflective space highlights how staff exited and managed the previous stage, which was facilitated by a culture of compassion within the team in which participants worked. The final category highlights the impact of the organisational system on this process.

### **Adopting a compassionate stance towards others**

#### *Caring for and connecting with the client*

Several participants discussed starting work with clients from a point of compassion. This compassionate stance encompassed a genuine connection to the distress and suffering they saw in their clients, "I sit and listen to her and inside I want to cry, I want to physically cry with her" (Donna), and empathy for the challenges their clients encountered, "she doesn't know how to manage that and I can see from her point of view that she's really kind of struggling with it" (Kath). In adopting this stance participants cared for and were accepting of the client, putting the clients' needs above their own.

#### *A desire to help*

Connecting with another's suffering led to a genuine aspiration to alleviate distress and to take action where possible, "we really desperately did want to help her to move on, to have a better quality of life" (Sophie). Participants described putting in huge amounts of effort to support clients and were "constantly trying to think of something to say, trying to think of something that's going to support or help that person" (Beth). Compassion was recognised as important in order to build a positive therapeutic relationship, and indeed, for most, as an essential pre-requisite for this type of work:

You can't be successful in your job without being compassionate and working in that way, it's gonna make your job easier, it's gonna improve peoples' quality of life, give you a better outcome (Adam).

#### *Personal Values and Spiritual Beliefs*

A number of facilitators were identified that enhanced a participant's drive to adopt this stance. Some participants described the influence of their personal values, such as fairness and non-discriminatory practice, and others spoke about the role of spiritual beliefs:

I mean I'm Buddhist so for me that is a massive thing, part of my life that helps me maintain empathy for other people and essentially I think I'd struggle to do the job [without it] (Evan).

Although staff felt compassion towards another's suffering, there was recognition that this vocation also satisfied their own needs and ideals, whether "it's emotional gratification or a financial gratification, we don't do things for nothing do we?" (Naomi). These personal needs facilitated their desire to help, again aiding their compassionate stance.

#### *Challenging preconceptions*

Despite this compassionate stance being a starting point for the engagement for most, participants described how threats to this stance could be present from the outset. Some participants explained how the attitudes of other staff towards a client could be influential, especially given the nature and duration of community mental healthcare. For example, Jenny noted, “nobody wanted this client you know, no thanks, but nobody really wanted to work with her”. Thus, the desired compassionate stance was vulnerable to the views held by other clinicians or service level preconceptions. However, participants noted how this threat could be overcome by detaching themselves from these attitudes and challenging them. Ways to achieve this included “starting from scratch” (Sophie) and viewing the client “as any other person and not the person I knew that his name kind of conjured up” (Adam).

### **The uphill struggle**

#### *Experiencing challenges*

When participants began to engage with clinical work, they encountered considerable challenges, which threatened their compassionate stance. Working with this client group could be unpredictable and draining, coupled with the necessity to manage high levels of risk, and at times, hostility:

The, erm, attachment and neediness of that client group, the instability and the emotional instability, the rapid change of things are ok and then they're not ok, suddenness of where you think you've got things planned and they're safe and then suddenly it will all fall apart the next day (Claire).

#### *“Never giving enough”*

Despite the challenges experienced, and driven by their compassionate stance, staff worked ceaselessly in order to try to help their clients and overcome these challenges. However, despite their repeated attempts and considerable expenditure of

time and energy, the outcome was often unsuccessful, leaving participants unrewarded, frustrated and exhausted:

No matter what it was that you said to her or how you managed that situation or how you offered support...no matter what you give it wasn't enough (Naomi).

This continued failure to achieve the agreed goals for the client could lead to feelings of hopelessness about the possibility of change. Participants viewed this process as cumulative, with the resulting feelings of frustration building over time.

*Being valued and noticing progress*

Several participants identified an exit to this process, disengaging from the challenges experienced and the sense they could never do enough. If participants perceived clients to value and appreciate their efforts and/or were able to observe clients making progress, no matter how big or small, it appeased this frustration. This prompted a positive emotional response, and acted as a facilitator of a return to the compassionate stance

*Activation of negative perceptions*

When the uphill struggle persisted, attributions about the client and their own clinical ability were activated. Variation existed in this; some participants attributed the failure to themselves, doubting their professional skills:

Sometimes you lose your own confidence in what you're doing because you don't, it ends up feeling like maybe you're the one with the issue, you're the one with the problem, that's why that person's not making any progress (Anna).

Others, however, attributed the difficulties to the client. This included adopting negative perceptions of the client and viewing them as lacking motivation or

responsibility for their actions. Some began making comparisons with clients without complex or challenging interpersonal difficulties and assumed a blaming, rather than understanding, perspective:

I was just so angry and wanted to throw the pen and say, 'That's it! I'm not spending any more time with you because you're just distracting my other cases, erm, people that wanna bloody move on, they wanna do something and you're here messing about here with (the) bloody washing line.' (Donna).

The activation of these attributions accentuated the feelings of frustration and left participants with a desire to end their contact with the client, withdrawing from their relationship. Whilst some alluded to the possibility that a time may come when they end their relationship with the client, only one participant had experienced this:

In the end I had to pass him on because I was dreading seeing him, I was not looking forward to seeing him, erm, running out of sort of [practical and emotional] resources (Beth).

#### *Difficulty in accessing a compassionate stance*

As a result of these feelings of frustration and inadequacy, participants reported a difficulty accessing their compassionate stance. For some, this was met with self-acceptance, "we're only human, there's only so much we can take" (Jenny), whereas others became self-critical. However, most participants described being able to regain their compassionate stance through accessing a reflective space (see below) and as such difficulties were relatively brief.

#### *"Spinning all these plates"*

The difficulties encountered in client work did not operate in isolation as the demands of an individual staff member's role influenced this uphill struggle, in particular their workload capacity. High workloads and increasing administrative

demands left participants feeling they were “spinning all these plates” (Kath), going from crisis to crisis and constantly “fire-fighting” (Claire). These pressures meant it became increasingly difficult to focus on the goals and needs of clients, part of adopting a compassionate stance, because of the necessity to juggle the many demands of the role, “You can feel a bit under siege, a bit under attack” (Claire). Responding to the increasing pressures and demands also reduced the amount of time to reflect on the work with clients (see below), which again made it harder to reconnect with the compassionate stance. The expectations of staff from other services also added to these pressures, consequently impacting on the uphill struggle.

### **Accessing a Reflective Space**

Accessing a reflective space was the key strategy that enabled participants to disengage from the uphill struggle and regain a compassionate stance. It involved reflecting on their work, and in particular on their relationship and understanding about their client, and could be done either alone or with colleagues.

#### *“Stepping back” and noticing emotions*

In order to access this space participants needed to pause and consciously attend to their own emotional responses and reduction in compassion, “again, it’s that reflection, you’ve just got to step back out of the situation” (Donna). In some situations this was prompted by the recognition that they needed to protect their own well-being, “You get to a stage where you have to sit back and recognise that there are things that you need to do in order to keep yourself safe” (Naomi). In other situations colleagues noticed participants’ state of mind and engaged them in discussion. Noticing and “stepping back” then prompted participants to access a reflective space either alone or with colleagues. The degree of reflective culture within the team and participant’s views about supervision and reflective practice more

generally featured as a determining factor for being able to and directing how to utilise the reflective space.

Although the majority of clinicians spoke about utilising colleagues when they discussed this process of reflection, on some occasions they also did it alone should colleagues be unavailable or should their preference be, on that occasion, to work independently:

I remember I'd always used to go and sit in my car afterwards and not drive off immediately. I used to look at myself in the mirror and I'd always be bright red and just sort of breath and just sort of compose myself and think, have a bit of a think before I drove off again about what had happened (Sophie).

#### *Utilising colleagues*

When reflecting with colleagues there were two possible functions; "sharing and feeling together" (Jenny) or getting advice and support. Emotional support was more likely to occur when colleagues noticed distress in the participant and consequently provided validation and normalisation of feelings. As a result of this participants were reassured and their feelings were "de-escalated" (Donna) and soothed. Knowledge based support was more likely to occur when colleagues were familiar with the client with whom participants were working, or perhaps were more experienced, and problem solving was then the main form of support:

You can come back and say, 'I've just seen such and such and I'm really struggling, I don't know what to do' and you'll find other experienced practitioners will tell you what to do next, and maybe 'have you tried this or have you tried to get them to think of a different way to focus their attention'. (Anna).



This advice gave participants confidence they could manage future situations and continue working with the client, which was viewed as empowering, “because you’ve got a plan (laughs). Next time I go I’m going to do this and see if it works” (Jenny), facilitating a re-connection with their desire to help and ultimately their compassionate stance.

*Reflecting on and developing an understanding*

For some, emotional or knowledge based support was enough to facilitate a reconnection with participants compassionate stance. For others, this space also provided time to reflect on and develop their psychological understanding of the client, either alone or with colleagues. In moments where compassion was difficult to access, reflecting on a client’s early experiences helped to bring compassion back to the forefront of participants’ work by recognising the impact childhood can have on adult life and a client’s current difficulties:

It’s trying to keep the understanding that their life experiences haven’t been great, which is why they respond in this way because, well its survival I believe in particular for the ones I work with (Donna)

This in turn reduced the level of frustration and anxiety experienced and facilitated a reconnection with the client and hence a return to the compassionate stance.

Indeed, reflecting on and developing an understanding of the client had a number of positive consequences. Participants described how an increase in understanding led to an improved relationship, which enhanced their compassionate stance, “I gained more compassion for her as I got to know her” (Jenny), with some suggesting the negative perceptions held about the client were then less likely to become activated. Furthermore, the process of hearing clients recount their history could in itself facilitate compassion as participants witnessed the vulnerability in

clients. Training and supervision from psychologists within the team also acted as part of the reflective space, again enhancing understanding of a client's background and subsequent interactions.

### *Culture of compassion*

When seeking support in the reflective space a compassionate response from colleagues had a soothing effect on participants. This not only aided their emotional regulation, but also facilitated a wider compassionate culture within the team. When colleagues trusted one another and held a strong drive to help alleviate each others distress the working lives of participants were improved, "I think if you have a good compassion focused team around you, so if you take care of each other better then that is easier to work in that way" (Adam). Furthermore, some participants spoke about how the high levels of compassion observed within the team were transferred to their relationships with clients and helped them regain their own compassion. The size of this compassionate culture varied, with some referring to this as a team-wide occurrence and others suggesting a small network of colleagues made up a compassionate culture, "there are certain people in the team who I am close to who I will vent and tell them. That often does the trick you know" (Beth). All participants described the importance of being in a supportive team environment and some speculated that without this there was a danger of becoming "defensive" or "swamped" (Adam), which could be reflected back to the client and interact with the challenges experienced by participants.

### **Working in a threatening system**

While participants reported experiencing the local team as compassionate the experience of working within a wider UK healthcare system of scrutiny and

increasing pressures was pertinent across interviews and forms the backdrop to the whole model.

*Professional Scrutiny*

Participants described a constant fear of suspension or litigation, specifically in relation to clients' self-harming or suicidal behaviour. For example, they worried whether they had sufficiently documented conversations and agreed plans of action with clients, in order to form a sufficient defence should an incident occur for which they might be accountable, "I have to admit that that is one of the first thoughts, have I covered everything" (James). This fear was driven by the reality that colleagues had been suspended or asked to attend a coroner's court in the past where their professional practice had been placed under scrutiny. Some participants were also concerned about whether they would have support from management at these times and how the policies in place do not necessarily allow for positive risk taking because of a fear around litigation:

Services are risk averse because of the fear of accountability and litigation and I think that is something that makes that difficult to work with erm, those clients in an environment like that, because you are under pressure from fear of accountability really to react to what they have done (Evan).

For some participants, the presence of this threat was, at times, seen to "get in the way" (Claire) of being able to connect with and maintain their compassionate stance.

Although the presence of working within a threatening system was always noted some participants described being able to protect themselves from this.

Collaborative practice, where care plans and decisions regarding risk were shared with team members and managers, and where the rationale for these decisions was clear appeared to help manage anxieties. This was further enhanced by staff's

confidence in their own practice, which some felt was built through experience, “I think it’s looking at the evidence, what outcomes you’ve had...reinforcing to yourself that this approach has been successful” (Adam), and the culture of compassion within the team.

#### *Targets and Resources*

Staff described constant systemic pressures with a focus on targets, coupled with fewer resources and limited time. Participants commented on being encouraged to constantly review their caseload to identify potential clients for discharge due to the increasing demand on the service. There was also an increasing pressure for participants to focus on quantity rather than quality within their interactions with clients, seeing more clients and spending less time with each one. Participants found these systemic pressures not only impacted on the service clients were offered, but also on their compassionate stance as it reduced their ability to spend time connecting with the client:

Somebody starts, quite often right before the end of a visit, they might come up with something that’s really important and you cant leave it there...time is an issue, and you say well we’ll have to talk about this next time because you’ve got another visit to go to or because that’s the end of the day and you’ve finished, so I think the time constraints sometimes can affect [the ability to be compassionate] (Sophie).

#### *Interaction with other conceptual categories*

An increasing systemic focus on targets alongside limited resources exacerbates the uphill struggle by heightening the demands described in “spinning all these plates” Concern over litigation encouraged participants to respond to risky situations, despite this not always being necessary, with some participants suggesting

this could perpetuate the challenges they experienced. It appeared that where the influence of the wider system had a greater presence staff had limited time to access a reflective space, allowing for the acknowledgment and management of difficult emotional responses, and consequently further impacted on their ability to adopt a compassionate stance.

### **Discussion**

The findings of this grounded theory informed project highlight how mental health staff perceived that their compassion towards clients could change, and the factors that influenced this process. The sequential model contains four conceptual categories, the first of which documents participants adopting a compassionate stance. However, when clinical work began participants experienced an uphill struggle, which resulted in difficulty accessing their compassionate stance. When this loss of compassion was noticed, either by themselves or others, participants accessed a reflective space and were able to regain their compassionate stance. This model sits within and interacts with the final conceptual category of working in a threatening system.

#### **Compassionate relating**

The compassionate stance contains many components of Gilbert's (2005) conceptualisation of compassionate relating. This includes the adoption of a non-judgemental, sympathetic, empathic, warm and caring approach that is able to tolerate and be sensitive to the distress of others, which Gilbert (2005) argues creates opportunities for growth and change. Interestingly, this compassionate stance was driven by the personal values and needs of the clinician, which could be likened to literature on the characteristics of helping professionals. Many authors have suggested

the influence of both conscious and unconscious factors in career choice, which according to psychodynamic theory leads to the fulfilment of unsatisfactory earlier attachments (Bowlby, 1977; Malan, 1979; Jacobs, 1991; Rycroft, 1993). Thus, the needs driving the adoption of a compassionate stance could relate to the needs of staff themselves.

### **The uphill struggle**

The uphill struggle documents the challenges participants faced in their work with clients with complex or challenging interpersonal difficulties and, as previously identified for staff in this setting, this often left them feeling inadequate and frustrated (eg. Ma, Shih, Hsiao, Shih & Hayter, 2008; Treloar, 2009). In part these emotional responses were a consequence of struggling to achieve agreed goals. Indeed, the focus on achievement within consumerist societies can lead to these feelings when goals are not achieved (Pani, 2000; Taylor, Gooding, Wood & Tarrier, 2011).

Perhaps most striking is the similarities between the uphill struggle and the concept of emotional exhaustion, a state of fatigue with diminished emotional capacity and a key concept within the experience of burnout (Maslach, 1982). There has been little research into the process leading to the occurrence of emotional exhaustion, despite the observation of high levels in mental health staff (Onyett, 2011). This project thus provides preliminary insight into a possible pathway to the occurrence of emotional exhaustion but importantly identifies a way for staff to reconnect with clients, via the reflective space, potentially avoiding this experience. Several authors have previously suggested the ability for staff to continue clinical work despite high levels of EE, specifically when there is a sense of personal accomplishment (Paris & Hodge, 2009; Stalker & Harvey, 20002; Onyett, 2011). Given, there has been little research into the relationship between compassion and

emotional exhaustion, this project highlights the potential link suggesting the need for further research.

As staff became increasingly frustrated, negative perceptions relating to the clients' difficulties increased and participants either attributed the responsibility of this frustration to themselves or their clients. Although there has been a plethora of research documenting the negative perceptions held by staff about this client group (Forsyth, 2007; Fraser & Gallop, 1993; Markham & Trower, 2003) and perhaps the experience of depersonalisation (Maslach & Jackson, 1981), this research provides novel insight into the process by which these occur and are activated and how this relates to compassion.

### **The utility of reflection**

Accessing a reflective space gave participants the opportunity to consider their own emotions, seek advice from others and/or develop their understanding of clients. Participants did this alone or with colleagues, however, the majority preferred to access this reflective space with colleagues. It could be argued that being with a compassionate other (or indeed a compassionate self) helped participants access self compassion (Gilbert, 2005). Self compassion has been conceptualised as entailing three interrelated components; being kind to self rather than critical, understanding human fallibility as a shared experience, and being mindful of ones distressing feelings rather than avoiding these (Neff, 2003a). Thus, it appears whilst in a reflective space participants were encouraged to be self compassionate. Compassion for others and compassion for self are not described as separate, distinct components but as interlinked entities (Neff, 2003a; Gilbert, 2009; Barnard & Curry, 2011). Recent research has speculated on the link between self compassion and compassion for others, suggesting those with higher levels of self compassion do more perspective

taking, show greater forgiveness, empathic concern, altruism and compassion for common humanity, as well as having lower levels of personal distress (Neff & Pommier, 2013). Thus, having higher levels of self compassion (or developing this) could be important in adopting and accessing a compassionate stance towards others.

Indeed, as a relatively new concept in academic literature, there has been little research into the effects of receiving compassion from others (Jazaieri et al., 2012). However, a number of models of supervision suggest the importance of the restorative, formative (Inskipp & Protor, 1994) and containing (Douglas, 2007) functions of supervision. Thus, through exploring and holding the emotional impact of clinical work and providing advice and education (as suggested by Douglas, 2007; Inskipp & Proctor, 1994), participants are 'soothed' (Gilbert, 2005) and consequently empowered to reengage with both their clinical work and compassionate stance.

While within a reflective space participants spoke about developing their understanding of the client, which enhanced their compassionate stance. Indeed psychological formulation has been shown to enhance staff's positive feelings and levels of confidence when working with service users and reduce negative attributions about clients, which may be due to an increased sense of control and hope for change (Berry, Barrowclough & Wearden, 2009).

### **Application to a model of affect regulation**

The model described in this research could be compared to the affect regulation model used within Compassion Focused Therapy (CFT; Gilbert, 2005). When considered alongside a CFT framework (Gilbert, 2005), putting in high levels of effort could be understood as the activation of the participants' drive system, which reinforces the activated threat system during the uphill struggle; an increasing threat system could lead to an increased drive system and vice versa (Gilbert, 2005). Not



only are participants' own threat systems being activated during the uphill struggle, there is the ever-present wider threat from working in community mental health teams, which perhaps exacerbates this. Furthermore, the utilisation of colleagues and the compassionate culture, which reduced participants' sense of threat and allowed them to re-engage with a compassionate stance, could be viewed as facilitating participants soothing system (Gilbert, 2005).

### **Clinical Implications**

Considering the lack of prior research in this area, the current study has implications for both clients and mental healthcare professionals, as well as for organisations. Participants described the importance of a compassionate culture within the mental health service and team they worked within, as well as the opportunity for reflection, in order for them to regain their compassionate stance. Interestingly, this may have implications for the current changes experienced by government-funded community based mental health services in the UK. Increasing caseloads and service demands, as well as an emphasis on lone working (Gilbert & Peck, 2014; McNicholl, 2013) could reduce the opportunities and amount of time staff have available to focus on reflective practice and access supervision, consequently reducing the opportunity to regain a compassionate stance. Reflective practice has long been evidenced as an essential part of working therapeutically with clients (Hughes & Youngson, 2009) and this study suggests further benefits related specifically to compassion.

#### *Developing self-soothing*

This study has highlighted the potential processes and practices required to develop staff's ability to self-soothe. This may be achieved, at least partly, by engaging in self-compassion and engendering a compassionate culture. There are strong links between self-compassion and psychological well-being, with greater

levels of depression, anxiety and stress found in those with lower levels of self-compassion (MacBeth & Gumley, 2012). However, staff may struggle to access soothing or self-compassion at times of difficulty, for example during the uphill struggle, as perhaps evidenced by the high levels of stress found in community mental health staff (Hannigan, Edwards, Coyle, Fothergill & Burnard, 2004). Given the importance of this, there is an argument for the incorporation of compassion orientated therapeutic groups for staff within mental health services. Groups such as this could increase clinicians' ability to tolerate threat, distress and discomfort by accessing and developing an effective way to self-soothe (Perseus, Kaver, Ekdahl, Asberg & Samuelsson, 2007), which may help with the uphill struggle. Furthermore, improving staff wellbeing not only has positive consequences for staff but also for service users. It has been documented that clients experience poorer treatment outcomes when staff have higher levels of emotional exhaustion and depersonalisation (Holmqvist & Jeanneau, 2006). Thus, an increased level of self-compassion could produce higher levels of resilience in staff helping them to cope with the struggles described in this model (such as self-doubt), whilst promoting change, and enhancing their general wellbeing (Rivers, 2012). In considering a CFT framework, increasing self compassion may also help to moderate the drive system (Gilbert, 2005) by encouraging staff to slow down and not engage in "knee-jerk reactions" (Evan), or perhaps access the reflective space, which may minimise the impact of their threat system when activated by the challenges faced in their interactions with clients or the wider system itself.

A number of participants reflected on the value of receiving training in helping them to develop their knowledge about psychological formulation and developing an understanding behind clients' actions, as well as in reducing the conviction of more

negative stereotypical attitudes towards clients with complex or challenging interpersonal difficulties (Berry et al., 2009). This thus suggests the importance of encouraging and allowing staff time to attend training, with psychologists being well placed to deliver this given their specialist skills in formulation (The British Psychological Society, 2011).

### **Limitations and future research**

Despite providing an insight into the process behind the loss and maintenance of compassion in community based mental health staff, limitations of the current project should be considered when assessing the credibility of these findings. First, all but one of the participants interviewed within this research described their ethnicity as 'White-British', suggesting the possible limited generalisability of the study to staff of other ethnic backgrounds. Considering research has highlighted the lower levels of emotional exhaustion in those from an ethnic minority (Nelson, Johnson & Bebbington, 2009; Wykes et al., 1997; Salyers & Bond, 2001), which may link to the conceptual category uphill struggle, future research may wish to consider whether the process behind the loss of a compassionate stance differs in staff from a variety of ethnic backgrounds.

All of the participants within this study were able to discuss times when compassion had been difficult to access but they were either able to regain it or, for one participant, they ended their relationship with the client before it became detrimental to the staff member's wellbeing. Furthermore, all participants were working with a team they described as compassionate. Therefore, although the outcome can be hypothesised, this model does not explicitly address what happens when accessing the reflective space is not possible and/or the uphill struggle is perpetuated. Future research could address this.

This research also solely focused on community mental health staff. Although the influence of stressors may differ between community and inpatient services (Edwards, Burnard, Coyle, Fothergill & Hannigan, 2000), it would be beneficial to consider whether this process, or a similar one, is pertinent within acute adult mental health. Furthermore, future research may wish to consider the perspective of other mental health professionals such as psychologists or psychiatrists, or consider the difference between participants self-accepting or self-critical stance to losing compassion.

### **Conclusions**

This grounded-theory informed research project set out to understand the process behind the loss and/or maintenance of compassion of community mental health staff working with clients with complex or challenging interpersonal difficulties. Through semi-structured interviewing with 11 participants a model consisting of four conceptual categories was developed. Staff started working with a compassionate stance but the struggles faced both with client work and managing threatening systemic factors led to difficulties accessing compassion. The importance of a reflective space and working in a compassionate culture were integral in facilitating a return to a compassionate stance. The findings of this study have important implications for staff and organisations in increasing the ability of staff to maintain a compassionate stance when working with clients with complex or challenging interpersonal difficulties.

### References

- Acker, G. (2011). Burnout among mental health care providers. *Journal of Social Work, 12, 5*, 475-490.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders*. (5th ed.) Washington DC, USA: American Psychiatric Association.
- Aviram, R. B., Brodsky, B. S., & Stanley, B. (2006). Borderline personality disorder, stigma, and treatment implications. *Harvard Review of Psychiatry, 14*, 249-256.
- Barnard, L. K., & Curry, J. F. (2011). Self-Compassion: Conceptualizations, Correlates, & Interventions. *Review of General Psychology, 15, 4*, 289-303.
- Berry, K., Barrowclough, C. & Wearden, A. (2009). A Pilot Study Investigating the Use of Psychological Formulations to Modify Psychiatric Staff Perceptions of Service Users with Psychosis. *Behavioural and Cognitive Psychotherapy, 37, 1*, 39-48.
- Birks, M. & Mills, J. (2011). *Grounded Theory: A Practical Guide*. London, UK: Sage Publications
- Bland, A., R. & Rossen, E., K. (2005). Clinical supervision of nurses working with patients with borderline personality disorder. *Issues in Mental Health Nursing, 26*, 507– 517.
- Bowlby, J. (1977). The making and breaking of affectional bonds. *British Journal of Psychiatry, 130*, 201–210.
- Boyle, M. (2007). The problem with diagnosis. *The Psychologist, 20*, 290-292.
- British Psychological Society. (2011). *Good Practice Guidelines on the use of psychological formulation*. Leicester, UK: British Psychological Society.

- Brody, E. M., & Farber, B. A. (1996). The effects of therapist experience and patient diagnosis on countertransference. *Psychotherapy, 33*, 372-380
- Care Quality Commission. (2011). *The state of health care and adult social care in England*. London, UK: Stationery Office.
- Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. London, UK: Sage.
- Charmaz, K. (2007). Grounded Theory. In J. A. Smith (Ed). *Qualitative Psychology: A Practical Guide to Research methods*. (2<sup>nd</sup> ed.). (pp. 80-110) London, UK: Sage.
- Cleary, M., Siegfried, N. & Walter G. (2002). Experience, knowledge and attitudes of mental health staff regarding clients with a borderline personality disorder. *International Journal of Mental Health Nursing, 11*, 186–191.
- Commons Treloar, A. J. & Lewis, A. J. (2008). Professional attitudes towards deliberate self-harm in patients with borderline personality disorder. *Australian and New Journal of Psychiatry, 42*, 578-584.
- Conklin, C. Z., & Westen, D. (2005). Borderline personality disorder in clinical practice. *American Journal of Psychiatry, 162*, 867-875.
- Crawford, P. (2011, October 14). *NHS failures in care for the elderly demand prompt remedies* [Letter to the Editor]. [London] Times, p. 35.
- Crawford, P., Gilbert, P., Gilbert, J., Gale, C. & Harvey, K. (2013). The Language of Compassion in Acute Mental Health care. *Qualitative Health Research, 23*, 719-727.
- Dey, I. (1999). *Grounding Grounded Theory Guidelines for Qualitative Inquiry*. Sand Diego, USA: Academic Press.

- Douglas, H. (2007). *Containment and reciprocity: integrating psychoanalytic theory and child development research for work with children*. Hove: Routledge.
- Edward, K. L. (2005). Resilience: A Protector From Depression. *Journal of the American Psychiatric Nurses Association, 11*, 241-243.
- Edwards, D. Burnard, P., Fothergill, A. & Hannigan, B. (2000). Stress and burnout in community mental health nursing: a review of the literature. *Journal of Psychiatric and Mental Health Nursing, 7*, 7-14
- Elliott, R., Fischer, C. T. & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-229.
- Epstein, R. M., Franks, P., Shields, C.G., Meldrum, S.C., Miller, K.N., Campbell, T.L., Fiscella K. (2005). Patient-centred communication and diagnostic testing. *Annals of Family Medicine, 3*, 415-21.
- Filer, N. (2005). Borderline Personality Disorder: attitudes of mental health nurses. *Mental Health Practice, 9*, 34-36.
- Forsyth, A. (2007). The effects of diagnosis and noncompliance attributions on therapeutic alliance in adult psychiatric settings. *Journal of Psychiatric and Mental Health Nursing, 14*, 33-40.
- Fraser, K. & Gallop, R. (1993). Nurses' confirming/ disconfirming responses to patients diagnosed with Borderline Personality Disorder. *Archives of Psychiatric Nursing, 7*, 336-341.
- Gilbert, P. (2005) *Compassion: Conceptualisations, Research and Use in Psychotherapy*. London, UK: Routledge.
- Gilbert, P. (2009). *The compassionate mind*. London, UK: Constable.

Gilburt, H. & Peck, E. (2014). *Service transformation: Lessons from mental health*.

The Kings Fund. Retrieved from [http://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/service-transformation-lessons-mental-health-4-feb-2014.pdf](http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/service-transformation-lessons-mental-health-4-feb-2014.pdf)

Glasser, A. (2005). *A Call to compassion: Bringing Buddhist practices of the heart into the soul of psychotherapy*. Berwick, ME: Nicolas-Hays.

Glaser, B. G. & Strauss, A. L. (1967). *The Discovery of Grounded Theory*. Chicago, USA: Aldine.

Gunderson, J. G. (2009). Borderline personality disorder: Ontogeny of a diagnosis. *American Journal of Psychiatry*, 166, 5, 530-539

Hannigan, B., Edwards, D., Coyle, D., Fothergill, A. & Burnard, P. (2000). Burnout in community mental health nurses: findings from the all-Wales stress study. *Journal of psychiatric and mental health nursing*, 7, 127-134.

Haywood, C. Jr., Lanzkron, S., Ratanawongsa, N., et al. (2010). The association of provider communication with trust among adults with sickle cell disease. *Journal of General Internal Medicine*, 25, 543-8.

Holmqvist, R. & Jeanneau, M. (2006). Burnout and psychiatric staff 's feelings towards patients. *Psychiatry Research*, 145, 207–213.

Horn, N., Johnstone, L., & Brooke, S. (2007). Some service user perspectives on the diagnosis of borderline personality disorder. *Journal of Mental Health*, 16, 2, 255-269.

Hughes, J. & Youngson, S. (2009). *Personal Development and Clinical Psychology*. Oxford, UK: Wiley-Blackwell.

Inskipp, F. & Proctor, P. (1994). *Making the Most of Supervision*. Twickenham: Cascade.



- Jackson, J. L., Chamberlin, J. & Kroenke K. (2001). Predictors of patient satisfaction. *Social Science Medicine*, 52, 609-20.
- James, P., D. & Cowman, S. (2007). Psychiatric nurses' knowledge, experience and attitudes towards clients with borderline personality disorder. *Journal of psychiatric and mental health nursing*, 14, 670-678.
- Kalapatapu, R. K., Patil, U., & Goodman, M. S. (2010). Using the internet to assess perceptions of patients with borderline personality disorder: What do patients want in the DSM-V? *Cyberpsychology, Behavior, and Social Networking*, 13, 483-494.
- Kaplan SH, Greenfield S, Ware JE Jr. (1989). Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Medical Care*, 27, 3, 110-27.
- Kraus, G., & Reynolds, D. J. (2001). The "A-B-C's" of the cluster B's: Identifying, understanding, and treating cluster B personality disorders. *Clinical Psychology Review*, 21, 345-373.
- Krawitz, R. & Watson, C. (2003). *Borderline Personality Disorder: A Practical Guide to Treatment*. Oxford, UK: Oxford University Press.
- Jacobs, M. (1991). The therapist's revenge: the law of talion as a motive for caring. *Interdisciplinary Journal of Pastoral Studies*, 105, 2-11.
- Jazaieri, H., Jinpa, G. T., McGonigal, K., Rosenberg, E. L., Finklestein, J., Simon-Thomas, E. et al. (2012). Enhancing compassion: A randomized controlled trial of a compassion cultivation training program. *Journal of Happiness Studies*, 14, 4, 1113-1126. .
- Lieb, K., Zanarini, M. C., Schmahl, C., Linehan, M. M. & Bohus, M. (2004). Borderline personality disorder. *Lancet*, 364, 453-61.

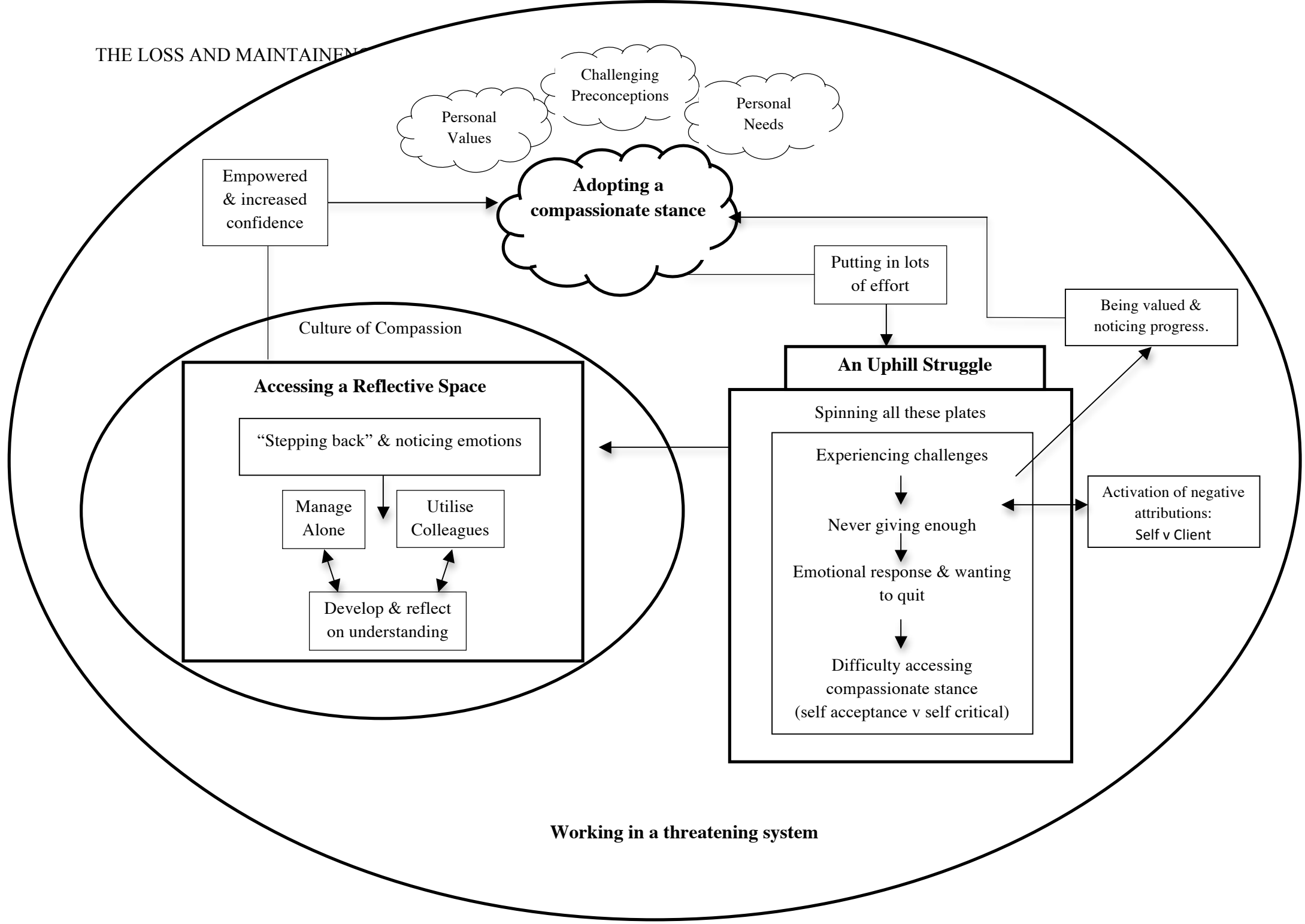
- Linehan, M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York: Guilford Press.
- Lown, B. & Manning, C. (2010). The Schwartz Centre Rounds: Evaluation of an Interdisciplinary Approach to Enhancing Patient-Centred Communication, Teamwork, and Provider Support. *Academic Medicine*, 85, 1073-81.
- Ma W.F., Shih F.J., Hsiao S.M., Shaw-Nin, S. & Hayter, M. (2008). 'Caring across thorns' – different care outcomes for Borderline Personality Disorder patients in Taiwan. *Journal of Clinical Nursing* 18, 440–450.
- MacBeth, A. & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review*, 32, 545-552.
- McCready, K. F. (1987). Milieu countertransference in treatment of borderline patients. *Psychotherapy*, 24, 720- 728.
- Malan, D. (1979). *Individual Psychotherapy and the Science of Psychodynamics*. London, UK: Butterworth.
- Markham, D. (2003). Attitudes towards patients with a diagnosis of 'borderline personality disorder': Social rejection and dangerousness. *Journal of Mental Health*, 12, 595-612.
- Markham, D. & Trower, P. (2003). The effects of the psychiatric label 'Borderline Personality Disorder' on nursing staff's perceptions and casual attributions for challenging behaviors. *The British Journal of Clinical Psychology*, 42, 243–256.
- Maslach, C. (1982). *Burnout: The cost of caring*. Englewood Cliffs, USA: Prentice Hall.

- Mason, T., Caulfield, M., Hall, R., & Melling, K. (2010). Perceptions of diagnostic labels in forensic psychiatric practice: A survey of differences between nurses and other disciplines. *Issues in Mental Health Nursing, 31*, 336-344.
- McNicoll, A. (2013). 'We are firefighting': the mental health funding shortage that's hitting frontline care. Retrieved May 2014, from [http://www.communitycare.co.uk/2013/12/12/firefighting-mental-health-funding-shortage-thats-hitting-frontline-care/#.U4cJl\\_ZgqUx](http://www.communitycare.co.uk/2013/12/12/firefighting-mental-health-funding-shortage-thats-hitting-frontline-care/#.U4cJl_ZgqUx).
- Meier, D., Back, A., Morrison, R. (2001). The inner life of physicians and care of the seriously ill. *Journal of the American Medical Association, 286*, 3007-14.
- Nauert, R. (2011). Compassion missing in American health care. Psych Central. Retrieved from <http://psychcentral.com/news/2011/09/09/compassion-missing-in-americanhealth-care/29295.html>
- Neff, K. (2003). Self-Compassion: An Alternative Conceptualization of a Healthy Attitude Toward Oneself. *Self and Identity, 2*, 85–101.
- Neff, K. (2003a). The development and validation of a scale to measure self-compassion. *Self and Identity, 2*, 223–250.
- Neff, K. & Pommier, E. (2013). The Relationship between Self-compassion and Other-focused Concern among College Undergraduates, Community Adults, and Practicing Meditators. *Self and Identity, 12*, 160–176.
- Nelson, T., Johnson, S. & Bebbington, P. (2009). Satisfaction and burnout among staff of crisis resolution, assertive outreach and community mental health teams A multicentre cross sectional survey. *Social Psychiatry and Psychiatric Epidemiology, 44*, 541–549.

- Newton-Howes, G., Weaver, T., & Tyrer, P. (2008). Attitudes of staff towards patients with personality disorder in community mental health teams. *Australian and New Zealand Journal of Psychiatry*, 42, 572-577.
- Ohaeri J. U. (2003). The burden of caregiving in families with a mental illness: a review of 2002. *Current Opinion in Psychiatry*, 16, 457-465.
- Onyett, S. (2011). Revisiting job satisfaction and burnout in community mental health teams. *Journal of Mental Health*, 20, 2, 198-209.
- Ortlipp, M. (2008). Keeping and using reflective journals in the qualitative research process. *The Qualitative Report*, 13, 4, 695-705.
- Pani, L. (2000). Is there an evolutionary mismatch between the normal physiology of the human dopaminergic system and current environmental conditions in industrialized countries? *Molecular Psychiatry*, 5, 467-475.
- Paris, J. (2005). Borderline personality disorder. *Canadian Medical Association Journal*, 172, 1579-1583.
- Paris, M. & Hoge, M. A. (2009). Burnout in the Mental Health Workforce: A Review. *Journal of Behavioural Health Services & Research*, 37, 4, 519-528.
- Perseius, K. I., Kaver, A., Ekdahl, S., Asberg, M. & Samuelsson, M. (2007). Stress and burnout in psychiatric professionals when starting to use dialectic behavioural therapy in the work with young self-harming women showing borderline personality symptoms. *Journal of Psychiatric and Mental Health Nursing*, 14, 635-643.
- Potter, N. (2006). What is manipulative behaviour, anyway? *Journal of Personality Disorders*, 20, 2, 139-156.

- Rayner, G. C., Allen, S. L. & Johnson, M. (2004). Countertransference and self-injury: a cognitive behavioural cycle. *Journal of Advanced Nursing*, 50, 1, 12-19.
- Rivers, Z. (2012, October) *The impact of working with complex personalities and trauma in secondary care- compassion fatigue and burnout: an affect regulation approach*. Poster presented at the Clinical Applications of Compassion Focused Therapy (CFT) conference.
- Rycroft, C. (1993). Why analysts need their patients' transferences. *British Journal of Psychotherapy*, 10, 83-87.
- Salyers, M. P. & Bond, G. R. (2001). An Exploratory Analysis of Racial Factors in Staff Burnout Among Assertive Community Treatment Workers. *Community Mental Health Journal*, 37, 5, 393-404.
- Soefer, S. (1999). Qualitative methods: what are they and why use them? *Health Services Research*, 34, 5, 1101-1118.
- Stalker, C., & Harvey, C. (2002). *Professional burnout: A review of theory, research and prevention partnerships for children and families project*. Brantford: Wilfrid Laurier University. Retrieved from [https://www.wlu.ca/documents/7177/Professional\\_burnout.pdf](https://www.wlu.ca/documents/7177/Professional_burnout.pdf)
- Stalker, K., Ferguson, I., & Barclay, A. (2005). 'It is a horrible term for someone': Service user and provider perspectives on 'personality disorder'. *Disability & Society*, 20, 359-373.
- Stuart, G., W. & Laraia, M., T. (2005). *Principles and Practice of Psychiatric Nursing* (8th Ed). Missouri, USA: Mosby Inc.

- Stewart, M., Brown, J., Donner A, McWhinney, I. R., Oates, J., Weston, W. W. et al. (2000). The Impact of Patient-Centred Care on Outcomes. *Journal of Family Practice*, 49, 796-804.
- Taylor, P., Gooding, P., Wood, A. N., & Tarrier, N. (2011). The role of defeat and entrapment in depression, anxiety and suicide. *Psychological Bulletin*, 137, 391–420.
- Vivino, B. L., Thompson, B. J., Hill, C. E. & Ladany, N. (2009). Compassion in psychotherapy: The perspective of therapists nominated as compassionate. *Psychotherapy Research*, 19, 2, 157-171.
- Watson, G., Batchelor, S., & Claxton, G. (Eds). (1999). *The psychology of awakening: Buddhism, science and our day-to-day lives*. London, UK: Rider.
- Woollaston, K., & Hixenbaugh, P. (2008). 'Destructive whirlwind': Nurses' perceptions of patients diagnosed with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing*, 15, 703-709.
- Wykes, T., Stevens, W. & Everitt, B. (1997). Stress in community care teams: will it affect the sustainability of community care? *Social Psychiatry and Psychiatric Epidemiology*, 32, 398-407.
- Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. Smith. (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods*. (2<sup>nd</sup> ed.). (pp. 235-252). London, UK: Sage Publishing.
- Zolnierek, K. B. & Dimatteo, M.R. (2009). Physician communication and patient adherence to treatment: a meta- analysis. *Medical Care*, 47, 826-34.



Working in a threatening system

## Appendices

### Appendix 2-A

#### Author Guidelines for The Journal of Mental Health

##### Instructions for Authors

Journal of Mental Health is an international journal adhering to the highest standards of anonymous, double-blind peer-review. The journal welcomes original contributions with relevance to mental health research from all parts of the world. Papers are accepted on the understanding that their contents have not previously been published or submitted elsewhere for publication in print or electronic form.

##### Submissions

All submissions, including book reviews, should be made online at Journal of Mental Health's Manuscript Central site at <http://mc.manuscriptcentral.com/cjmh>. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting. Authors will be asked to add this information in section 4 of the on-line submission process.

The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count.

Manuscripts will be dealt with by the Executive Editor, Professor Til Wykes, Department of Psychology, Institute of Psychiatry, De Crespigny Park, London, SE5 8AF, United Kingdom. It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process. The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing.

Book Reviews. All books for reviewing should be sent directly to Martin Guha, Book Reviews Editor, Information Services & Systems, Institute of Psychiatry, KCL, De Crespigny Park, PO Box 18, London, SE5 8AF.

Manuscripts should be typed double-spaced (including references), with margins of at least 2.5cm (1 inch). The cover page (uploaded separately from the main manuscript) should show the full title of the paper, a short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names, the exact word length of the paper and affiliations of authors and the address where the work was carried out. The corresponding author should be identified, giving full postal address, telephone, fax number and email address if available. To expedite blind reviewing, no other pages in the manuscript should identify the authors. All pages should be numbered.

Abstracts. The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The



declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content.

#### Keywords

Authors will be asked to submit key words with their article, one taken from the picklist provided to specify subject of study, and at least one other of their own choice. Text. Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Key Words, Main text, Appendix, References, Figures, Tables. Footnotes should be avoided where possible. The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count. Language should be in the style of the APA (see Publication Manual of the American Psychological Association, Fifth Edition, 2001).

Style and References. Manuscripts should be carefully prepared using the aforementioned Publication Manual of the American Psychological Association , and all references listed must be mentioned in the text. Within the text references should be indicated by the author's name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes et al ., 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by author (showing the names of all authors), in the following standard forms, capitalisation and punctuation:

a) For journal articles (titles of journals should not be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. *Magnetic Resonance Imaging*, 18 , 351–355.

b) For books:

Powell, T.J. & Enright, S.J. (1990) *Anxiety and Stress management* . London: Routledge

c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In G.Parry & F. Watts (Eds.), *A Handbook of Skills and Methods in Mental Health Research* (pp. 75–89). London:Lawrence Erlbaum.

Illustrations should not be inserted in the text. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should

be indicated in the text. A list of captions for the figures should be submitted on a separate page, or caption should be entered where prompted on submission, and should make interpretation possible without reference to the text. Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied. Tables should be typed on separate pages and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should not be used.

#### Accepted papers

If the article is accepted, authors are requested to submit their final and revised version of their manuscript on disk. The disk should contain the paper saved in Microsoft Word, rich text format (RTF), or as a text or ASCII (plain) text file. The disk should be clearly labelled with the names of the author(s), title, filenames and software used. Figures should be included on the disk, in Microsoft Excel. A good quality hard copy is also required.

Proofs are supplied for checking and making essential corrections, not for general revision or alteration. Proofs should be corrected and returned within three days of receipt. Early Electronic Offprints. Corresponding authors can now receive their article by e-mail as a complete PDF. This allows the author to print up to 50 copies, free of charge, and disseminate them to colleagues. In many cases this facility will be available up to two weeks prior to publication. Or, alternatively, corresponding authors will receive the traditional 50 offprints. A copy of the journal will be sent by post to all corresponding authors after publication. Additional copies of the journal can be purchased at the author's preferential rate of £15.00/\$25.00 per copy.

Copyright. It is a condition of publication that authors transfer copyright of their articles, including abstracts, to Shadowfax Publishing and Informa Health care. Transfer of copyright enables the publishers to ensure full copyright protection and to disseminate the article and journal to the widest possible readership in print and electronic forms. Authors may, of course, use their article and abstract elsewhere after publication providing that prior permission is obtained from Taylor and Francis Ltd. Authors are themselves responsible for obtaining permission to reproduce copyright material from other sources.

## Appendix 2-B

## Participant Demographic Information

<b>Pseudonym</b>	<b>Gender</b>	<b>Age</b>	<b>Professional Background</b>	<b>Years since qualifying</b>	<b>Years working with this client group</b>
Kath	F	58	O.T	21	20
Claire	F	48	CPN	24	21
Donna	F	55	Social Work	5	3 ½
Sophie	F	45	O.T	19	19
Anna	F	32	CPN	10	10
Beth	F	45	CPN	19	19
Evan	M	32	Social Work	4	7
Jenny	F	37	CPN	15	15
James	M	55	CPN	16	16
Naomi	F	48	CPN	19	19
Adam	M	38	CPN	12	12

Appendix 2-C

Example Transcript Excerpt and Coding for sub-categories:

Experiencing Challenges / Utilising Colleagues / Professional Scrutiny

Transcript Excerpt	Line by Line Coding	Focused Coding / <i>Sub-category</i>
<p>I: right, so I might come back to that what you said then about people not having time to reflect. Erm, just before we talk about that I'm wondering if you feel like there are any specific challenges with working with this kind of client group?</p> <p>R: I think it depends on the disorder, it depends on the person and my own perspective. I think working with people who are a bit more anxious/avoidant dependant personality traits, that's more difficult because its more refractory, its harder to treat, the outcomes are harder to identify and get to. In terms of BPD I feel quite happy, I know what I'm dealing with really. Same as with people with dissocial personality disorder. I think for other people its, there not as used to dealing with people with personality disorder. I come from a team where were quite inclusive anyway, even after 2003 document, so its always been, we've always looked after people with PD and we've always had robust clinicians and robust support systems in place, whereas I'm relatively new to this team, I've been here 3 years, but that doesn't seem to be the case. Erm, I think people feel overwhelmed and frightened and anxious and sensitive and they worry about, I think people worry, my threshold for self injury is a lot higher for a lot of my peers might be, in terms of if its framed within the context of, erm, coping strategies, managing stress that kind of stuff, so I've got a lot more wiggle room than a lot of people.</p>	<p>Experiencing different challenges with different clients</p> <p>Finding it difficult to make changes</p> <p>Having robust support systems</p> <p>Observing others feel overwhelmed and frightened</p> <p>Acknowledging lower threshold for what makes anxious</p> <p>Having more 'wiggle room'</p>	<p>Uniqueness of each client &amp; the challenges faced <i>Experiencing challenges</i></p> <p>Importance of support systems <i>Utilising Colleagues</i></p> <p>Observing impact of threat on others <i>Professional Scrutiny</i></p>

<p>I: yea, so you talked then about risk being a challenge for some people and sitting with that anxiety. Are there any other challenges?  R: well I think, yea, well just the, I think people can find it quite draining on an interpersonal level, erm. I've just done the cuff training and the train the trainers course with my first cohort and it really is about raising awareness and not demonising people I think and not, we create problems.  I: how do you think you do that then, how do you think you raise awareness and not demonise?  R: for me I think its about directing people to the cuff training and case by case, clinician by clinician basis, at my kind of level just sitting down with them and unpicking something with somebody, thinking about why people might feel or behave a certain way.  I: when you've been working with clients, maybe with sort of a more typical borderline presentation, have you ever kind of found it really hard to maintain compassion towards them?  R: yea sometimes,  I: can you tell me about an example?  R: erm, like an overarching compassion but when your in the moment, there's a lady who we changed her care plan, with her consent, and put that we would move hospital admissions for her and there's been a couple of occasions where she would throw me out of the flat because I wouldn't admit her. And ten to five on a Friday she would phone me saying I hope you have a nice weekend because I'm going to kill myself tonight. and I was 99% sure she wouldn't, and she might harm herself and go to a and e but I was pretty sure that we would, she wasn't going to kill herself. So I suppose in that 10 minutes or when I'm driving home then obviously your frustrated and your annoyed but there's an overarching erm, taking the longer view.</p>	<p>Working with clients draining on an interpersonal level.  Raising awareness about PD  Helping staff to unpick way client is behaving in a certain way  Experiencing an overarching compassion but momentary lapses  Making changes  Having demands placed on you  Receiving threats of suicide from client  Feeling confident in decisions  Feeling frustrated by client  Linking frustrations to compassion.</p>	<p>Working with clients draining on an interpersonal level.  <i>Experiencing challenges</i>  Thinking about the meaning behind action  <i>Reflecting &amp; developing understanding</i>  Feeling confident in decisions  <i>Professional Scrutiny</i></p>
--	--	---

<p>I: Mmm, tell me about that, tell me what you mean by an overarching compassion and a momentary compassion, what's that look like?</p> <p>R: well one of the student nurses they see people with personality disorder, erm, the 2 things I want you to think about are they wouldn't choose to feel like they do or do what they do, and there's always somebody else's fault as to why they are how they are. So, just those kind of frames of reference really but I think in the moment if someone is being obnoxious to you or threatening, or you feel they're backing you into a corner, erm</p> <p>I: so how do you think you maintain an overarching compassion when you loose the compassion in the moment do you think?</p> <p>R: you let it settle, you have supervision, you do reflect on it, you know. The systems that we kinda of have, clinical supervision, peer support, bringing it back to the client. More often than not people apologise if they're really arsy, but bringing it back saying I'm not happy with what kind of happened on Friday or whenever, what was going on</p> <p>I: how do you think the kind of, you said then about using peers, having supervision, how does that help? Quite a lot of people have said that but how does it actually help?</p> <p>R: it's a process isn't it? So its, it relieves stress, it allows you to ventilate your own anxiety, pressure, erm, it can give you feedback. You know it might be somebody saying your doing the right thing, keep going, what your doing is fine, erm. I suppose it's the active process of reviewing what your doing is in yourself, it is a process, and its, it kind of goes on all the time but to do that in a more formal or a more separate kind of time and place when your not as clouded by how your feeling at the time.</p> <p>I: Mmm, so coming away from the situation is really helpful in that</p>	<p>Promoting understanding that client wouldn't choose to act this way. Threatening behaviour influencing compassion</p> <p>Taking a step back allows maintain overarching comp even when loose momentary Utilising supervision Bringing it back to the client &amp; being open about what happened.</p> <p>Peers/sup-Relieving stress, ventilating anxiety, receiving feedback Having experience of validating what doing. Reflecting on what your doing yourself &amp; reviewing it Doing it separate so not as clouded by feelings.</p>	<p>Developing an understanding of behaviour <i>Reflecting &amp; developing an understanding</i></p> <p>Taking a step back allows maintain overarching comp even when loose momentary <i>Stepping back and noticing</i></p> <p>Peers/sup-Relieving stress, ventilating anxiety, receiving feedback, steps back from feelings so not clouded. <i>Utilising colleagues</i></p> <p>Reflecting alone on what your doing &amp; reviewing it <i>Managing alone</i></p>
---	--	---

<p>circumstance?  R: yea, id say so  I: what do you think, so your speaking in supervision and you were speaking and relieving stress and explain the situation and the things you talked about then about being able to vent and manage your anxiety and get feedback, how does that then help you then go back to the client? what's that doing to you as a practitioner?  R: I think it keeps you robust and resilient, it recharges your batteries a bit for the next time to go again. This lady we had, we had core group meetings with her, where she would come to every meeting with crisis team liaison, erm, myself and we had a team, we built a team around her, with named clinicians for each team but separate to that we would have professional meetings as a means of doing that in a more team way, so I think it just recharges your batteries a bit.  I: yea, some people have talked about, erm, it gives you confidence as well in your ability. How do you feel about that?  R: I'm fairly ok in terms of what I do with this group of people erm because, again using supervision and reflections as an active kind of process has been the outset of it even before we looked at kind of working in a risk, well more positive risk taking way I kind of discussed it with the lead consultant and the lead for self injury at the time, and I think the psychologist in our team and I just think, the courage convictions of what your doing is kind of the right thing to do. I think just being really stubborn.</p>	<p>Supervision when loose- keeping you robust &amp; resilient  Recharging batteries.  Building a team around client  Using the team to help manage the stress</p> <p>Having confidence in what you do  Using supervision as a way to reflect on actions  Seeing supervision as an active process  Discussing plan with other professionals  Having courage and belief in your decisions</p>	<p>Supervision- keeping you robust &amp; resilient  <i>Utilising colleagues</i></p> <p>Utilising colleagues-managing stress  <i>Utilising colleagues</i></p> <p>Having confidence in what you do.  Using supervision as a way to reflect on actions  <i>Utilising colleagues</i></p> <p>Having courage and belief in your decisions  <i>Professional Scrutiny</i></p>
---	---	---

Example Transcript Excerpt and Coding for sub-categories:

Spinning all these plates / Activation of negative perceptions / Never giving enough / A desire to help

Transcript Excerpt	Line by Line Coding	Focused Coding / <i>Sub-category</i>
<p>I: So how do you, so you talked then about feeling like there's a "chink in your armour" and that you've failed a little bit. How do you kinda mange that feeling? What do you do with that?</p> <p>R: erm, erm, I mean I, I suppose in a formal way we have supervision and people will sit down and you reflect on why you made that decision and you try and make it a team decision, so you try and get doctors involved in that so your not carrying the weight, you know I've tried everything and it looks like things are just so risky now that they are needing to be of different services that they kind of go across really you know. For example, somebody admitted. So I think reflecting on things and people sort of, colleagues and peers, and informally in the office, saying oh you've done what you could [participants name] and you've taken this and you know, and so, so I kind of manage it that way.</p> <p>I: does it work? does that work</p> <p>R: erm, I, I, defy anybody, I mean, I always admire people who erm, I think you get all the 'oh I wont take any shit' you know and that, but I defy anybody doesn't at times question you know when there, coz sometimes it does feel like your under attack, you've got staff attacking you 'could you not have done this or' and then the patient can sometimes can be seen as hostility there and problems there as well if your not making decisions that they, erm, are against what</p>	<p>Seeking supervision                      Reflecting on your decisions.                      Working within a team, getting others involved for support.                      "not carrying all the weight"                      Exhausting all the options                      Reflecting on what's happened.                      Utility of peers &amp; colleagues.                      Others providing reassurance.</p> <p>Admiring how colleagues manage things.                      Acknowledging everybody questions their own actions.                      Being attacked by staff, questioning you decision.                      Managing hostility from client.</p>	<p>Involving others  <i>Professional Scrutiny</i></p> <p>Utilising colleagues- seeking support &amp; reassurance &amp; reflecting  <i>Utilising colleagues</i></p> <p>Learning from colleagues.  <i>Utilising Colleagues</i>                      Others questioning your decision.  <i>Spinning all these plates</i>                      Hostility from client  <i>Experiencing challenges</i></p>



<p>maybe they want or you know aren't going to be therapeutic.  I: gosh it sounds like you kind of managing quite a lot and  R: It is really yea, because you've got all they're baggage and stuff and you've got the expectations of different services that they kind of go across really you know. For example, somebody is frequently using an advice line and you know they are using it inappropriately or you know and its sort of left, you know how do we solve this how do we stop them doing this. And sometimes things, and it's a long game as well, people want quick fixes don't they you know, we'll do this care plan and you know, sometimes, its chipping away isn't it, trying to effect change through the relationship and the longevity of that over time. But people want instant sort of decreases in bed occupancy or a decrease in harm or  I: so you're talking about quite a lot of [systemic factors] in a way about other agencies [as well as] and not just your work with that [client] its all quite broad.  R: [yes] [yea yea] [yea] It is, because obviously bed manages they've got gate keeping responsibilities and to a degree I have as well you know, so they've got there own agenda and then my agenda is sort of you want to keep somebody safe, you want to maintain a relationship, a therapeutic relationship, erm, and you also want to help somebody live more meaningful lives and exit that sort of that risky, unstable behaviour that maybe leads to inpatient admission that has no long sort of therapeutic value and then they're discharged and fall out from that, and back in to the cycle again and you're trying to help people move on to more, to better ways of living, but you can come into conflict with that.  I: You talked, you mentioned then about cycle in a way. I guess I'm wondering what its like to have a cycle, to be going from inpatient to</p>	<p>Managing disagreement between self &amp; client on next step.  Carrying clients 'baggage'  Expectations from services  Managing competing demands  Having to problem solve re clients behaviour.  Expectations of others; "quick fix"  Reality that it's about "chipping away".  Using the TR to help change.  Expectations of others: "instant" changes.</p> <p>Understanding why others place expectations..Self as having a multifaceted role.  Conflicting agendas?  Showing compassion, wanting to help.  Having ideas what client needs.  Doing something you know has no therapeutic value?  Anticipating reactions of clients, cycle  Always "trying to help"</p>	<p>Expectations of others  <i>Spinning all these plates</i></p> <p>TR as a vehicle for change.</p> <p>Expectations of others  <i>Spinning all these plates</i></p> <p>Holding many perspectives</p> <p>Wanting to help  <i>A desire to help</i></p>
--	--	---

<p>community to crisis. What's that like, working with someone who's in a cycle?</p> <p>R: erm, erm, frustrating I guess at times. It can be, erm, erm, I suppose exhausting and draining and you want people to sort of, sometimes it feels like two steps forwards and three steps back, and you think you may have broken that cycle and then it starts up again. Erm, erm, frustrating coz your dealing with so many different agencies across services, erm, I'm sorry I've forgotten the question again [Laughs].</p> <p>I: [laughs] its ok</p> <p>R: Yea I'm trying to think of erm somebody recent in a cycle how it would feel, erm. I don't know, is it, I mean sometimes its very hard not, your very mindful of not wearing, you know, somebody who you've worked really hard with and you think you've got a very effective plan that they have collaborated on, one that they've kind of bought into and then next minute they've gone to A &amp; E and they've got admitted again and something risky's happened, and so on. And then you start to just oh this is just getting frustrating, I just feel this is just my energy and time that I've spent with that person, you know, they've got nothing invested in moving on. I think some, I'm going off on a tangent here, but things with other, things with emotionally unstable, that type of client group we work with, even using the word recovery can have so many negative connotations for them because it means loss, it means you might not see them as often or stepping back, you know, any sort of I want you to have a more meaningful life can have other meanings to them about rejection and abandonment and so on. Erm.</p> <p>I: how do you think all those kind of, you said then about how it can be frustrating coz you've broken the cycle and then that cycle starts over again. How do you think, I mean it might not, but does that</p>	<p>Experiencing frustration at "cycle".          Feeling exhausted, drained.          Taking "two steps forward &amp; three steps back"          Having hope you've broken the cycle but being disappointed?          Managing a lot of pressures</p> <p>Acknowledging difficulties.</p> <p>Working collaboratively with clients          Developing a plan with clients &amp; then this not working... disappointment?</p> <p>Putting in your all...wasted?          Feeling like the client isn't taking any responsibility to move on.          Picking your language carefully.          Understanding the multiple meanings of language to clients.          Experiencing clients feeling rejected or abandoned if moving forward.</p>	<p>Experiencing frustrations: two steps forward &amp; three steps back"          Having hope but being disappointed when back in cycle.  <i>Never giving enough</i>          Managing pressures from other services.  <i>Spinning all these plates</i></p> <p>Disappointment when things don't work.  <i>Never giving enough</i></p> <p>Putting in a lot of effort.  <i>Never giving enough</i>          Lack of responsibility on clients part.  <i>Activation of negative perceptions</i>          Having a deeper understanding of behaviour</p>
---	---	---

<p>impact on how can relate with that client, and how you feel towards them?  R: erm, yea, I think it, you can, its erm, I don't think you'd be human if you didn't at times feel you know, I feel I feel a bit angry about this situation. I mean I went to visit somebody yesterday whose just been admitted, for example, and erm, she's fairly new to our service, certainly there's very strong personality traits and she's incredibly needy and has taken multiple overdoses over the last few weeks, but we've, over the last few months we should say, but over the last sort of 4, 5 weeks we've tried to work quite intensively with her, psychology, support worker. And we saw her on Friday and have quite a positive meeting with her and I felt quite optimistic we were making some small crumbs of progress even though she has had a very difficult time and has been very chaotic, and then when I came I on Monday, on the Saturday she had taken a big overdose and had gone to her neighbours house, the neighbour had phoned an ambulance and the ambulance service took her to A &amp; E and she had got violent at A &amp; E and the police were involved and she was admitted, she was sectioned, and she was admitted to [name removed], erm, very similar to a previous admission and I just felt a bit deflated and a bit ahh, what good has all this done, you know, and when I went on the ward the first thing yesterday was the staff wanted to talk to me, well I said, I don't want, you know, nobody wanted this admission to be long, but I didn't have any answers as to how we move this forward at the moment, erm, which I think they were seeking, do we have a plan, and then when I went to see the lady, you know, she was very difficult and you know she was stroppy and hostile, and clearly just wanted to be in hospital even though she was saying she wanted to leave because she was quite lonely and had made contacts in hospital, but that whole cycle it, it felt</p>	<p>Being human  Visiting somebody.  [Info about client]</p> <p>Being constantly needed by client.</p> <p>Working intensively  Getting other professionals involved.  Feeling positive about work, optimistic, making progress despite obstacles.</p> <p>Feeling deflated...all work put in</p> <p>Others requesting your time.  Not having the answers  Others seeking answers from you.</p> <p>Experiencing client as "stroppy &amp; hostile".  Understanding clients perspective, showing know why.  Cycle</p>	<p>Being human/acceptance  <i>Difficulty in accessing a compassionate stance</i></p> <p>Being in demand  <i>Experiencing challenges</i></p> <p>Seeing progress as positive  <i>Being valued &amp; noticing progress</i></p> <p>Deflated when cycle returns.  <i>Never giving enough</i></p> <p>Expectations from other services.  <i>Spinning all these plates</i></p> <p>Importance of understanding</p>
---	--	---

<p>like, were going to be here again and again and again, you know, and erm this is just exhausting and the paper work involved in it all you know reviewing the care plan, updating the risk assessment, you know, erm, yea. And when I saw her, I was trying to keep myself in check but she was quite, you know, ‘how are you feeling’, ‘like crap’, and she’s a bit sort of, she uses a lot of shocking language anyway, monosyllabic ‘life’s shit’ and all that sort of thing, and I felt quite angry with her. All that time, you know, trying to get psychologist involved and you know, getting her to the top of the list for support workers, even thought there’s a massive list, and then you know this happens and its just crazy really, why she did it, because its of no, she clearly didn’t really wanna kill herself because she immediately alerted services, and for weeks we’ve been very carefully delivering her medication weekly and her daughter was supervising it, and all the time she had been hoarding it on the top shelf and had been using it to take a big overdose on Saturday. So I just felt like aaahh the whole, you know, the whole thing. So its kind of, yea, I felt angry and frustrated and you know I felt a bit let down, I try not to reflect that to her because then I suppose she’d feel angry, frustrated and let down you could say it might mirror how she felt, I don’t know, but yea you just sort of think, oh no, groundhog day</p>	<p>Experiencing repetition                  Feeling exhausted with it.                  Updating paperwork...lots...                  overwhelming?                  Managing own emotions.                  Trying to engage client                  Conversation not being reciprocal                  Feeling angry with client.                  Putting in a lot of effort getting client help and feeling like its not helped.                  Trying to understand                  Viewing attempts as futile</p> <p>Sense of betrayal by client?                  Feeling angry, frustrated &amp; let down.                  Projection? Feeling how she felt?                  Psychological thinking</p>	<p>Workload pressures-                  Juggling many tasks  <i>Spinning all these plates</i></p> <p>Putting in a lot of effort but not helping  <i>Never giving enough</i></p> <p>Feeling let down by client as not taking responsibility  <i>Activation of negative perceptions</i></p> <p>Resulting emotional response  <i>Never giving enough</i></p> <p>Psychological thinking-                  projection / mirroring                  Wanting to help  <i>A desire to help</i></p>
---	--	--

## Appendix 2-D

## Categories and Sub-Categories

---

<b>Conceptual Category</b>	<b>Sub-Category</b>
Adopting a compassionate stance	Caring for & connecting with the client
	A desire to help
	Personal Values & Spiritual Beliefs
	Challenging preconceptions
The uphill struggle	Experiencing challenges
	Never giving enough
	Being valued & noticing progress
	Activation of negative perceptions
	Difficulty in accessing compassion
	“Spinning all these plates”
Accessing a reflective space	“Stepping back” & noticing emotions/ Managing alone

Working in a wider system

Utilising colleagues

Reflecting & developing an understanding

Culture of compassion

Professional Scrutiny

Targets & resources

---

## Appendix 2-E

## Example of a Memo

Memos took the form of written or diagrammatic notes. The following memo relates to the sub-category 'reflecting and developing an understanding'.

Participants consistently spoke about the utility of generating an understanding about the client's actions, most specifically when challenges and frustrations presented themselves. This understanding might be a psychological formulation linking early experiences to current behaviour or may involve reflecting on the deeper meaning behind client's current actions. In generating an understanding and considering this participants felt they were able to bring themselves back to a compassionate stance, because they understood why someone was acting in a certain way and neglected stereotypical views that are often discussed in relation to clients with this diagnosis, such as being manipulative, intentionally disruptive or selfish. This understanding helped participants to acknowledge the importance of client's early experiences on their adult life and helped to remember that these experiences stay with clients. I wondered whether taking this view actually facilitates a compassionate stance in itself as you are viewing a client with an empathic understanding; participants spoke about understanding actions might be a learned way of coping and that this was understandable, as anyone would act this way given their experiences. Furthermore, participants spoke about the emotional impact of hearing clients histories and feeling sadness that someone experienced this. Participants felt this in itself fostered compassion.

However, when participants struggled to generate an understanding it negatively impacted on their compassion as they struggled to maintain this and began to adopt negative stereotypes that blamed the client for their actions. This led me to

think about the importance of including the negative attitudes expressed in the interviews as an integral part of the process towards a compassionate stance. When these views are solely present it proves difficult for participants to find a compassionate stance, both in the moment with the client and during the interview, because they struggle to comprehend why a client may act in this way.

Interestingly the generation of this understanding is dependant on the therapeutic relationship. When participants hadn't fully developed a therapeutic relationship with their clients it was hard to generate an understanding and thus harder to maintain compassion in the face of difficulties. Furthermore, for some participants a lack of an understanding led to a disconnection from the client, which consequently affects the therapeutic relationship, and compassionate stance.

Participants discussed the impact of an understanding on managing risk and directing action. When a formulation or understanding about a client is present it helps staff manage risk and feel less anxious about their role and responsibility in this. One also wonders if it links in to the uncertainty expressed by participants when they often feel as though they "don't know what they're doing"?



### **Section Three: Critical Appraisal**

#### **Compassion and Burnout in Community Mental Health Work**

**Word Count: 3976**

Rachel Wass (nee Watts)

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

**All correspondence should be sent to:**

Rachel Wass (nee Watts)

Doctorate in Clinical Psychology

Furness College

Lancaster University

Lancaster

LA1 4YT

[r.watts@lancaster.ac.uk](mailto:r.watts@lancaster.ac.uk)

## **Introduction**

This study aimed to consider the process behind the loss and maintenance of compassion within community based mental health professionals. Utilising a grounded theory informed methodology, four core conceptual categories emerged from the data; the adoption of a compassionate stance; the uphill struggle; accessing a reflective space and working within a threatening system. The interaction between these core categories, the extent to which this process may vary for individuals and the study strengths and limitations are discussed in the empirical paper. However, within this critical appraisal I will offer an extension of the findings previously discussed and offer personal reflections on conducting this research. I will also comment on the challenges and decisions made with regard to this project. Thus, this critical appraisal will consider three main areas: ‘finding the right terminology’, ‘extending the study findings’ and ‘reflecting on the presence of compassion’.

### **Finding the right terminology**

#### *The use of diagnostic terminology*

There has been growing speculation about the reliability, validity, usability and evidence base for the use of diagnostic terminology within mental healthcare (Kinderman, Reed, Moncrieff, Bentall, 2012). The introduction of the latest Diagnostic Statistic Manual (DSM; American Psychiatric Association, 2013) saw debate among mental health professionals, particularly within clinical psychology, about the increasing and unnecessary pathologisation of distress (Division of Clinical Psychology, 2013). Having avoided the use of diagnosis within clinical practice, unless advocated by the client, I needed to make a decision about the use of this within my research activity.

In contrast to the debate regarding the use of diagnosis in clinical practice, there have been limited discussions about the use of diagnostic criteria in research. Some authors argue the use of diagnostic categories allows for clarity and reliability about the sample used (Kendall & Jablensky, 2003). Others suggest it negatively constrains the focus of research activity (Carey, 2013) and leads to nothing more than inferential assumptions (Slade & Preibe, 2001). Despite this it is often viewed as a necessity for publication or in gaining research grants (Wykes, 2013). Unfortunately, few have offered alternatives; Pilgrim (2013) argues research should focus on “single symptoms or shared predicaments” (p.1).

Previous research has suggested the use of diagnostics in ‘borderline personality disorder’ is inherently stigmatizing (Mason, Caulfield, Hall & Melling, 2010), lacks validity (Boyle, 2007) and is aversive to service users (Horn, Johnstone & Brooke, 2007). Thus, in line with the views of service users and my own values and beliefs around diagnosis, I made the decision not to adopt a diagnostic approach. I also considered whether this was also a good opportunity to promote an alternative approach to diagnosis with community mental health staff. However, in avoiding diagnosis, I was aware I still needed a way to focus my area of inquiry within the project and during interviews with staff. Having sought supervision regarding the issue, my supervisor and I generated the phrase ‘working with clients with complex or challenging interactions’ as we felt this represented the difficulties faced by clients and staff, as well as the term removing the difficulty from within the client to their interactions and ways of relating. In order to ensure staff understood this terminology a face validity test was carried out. My supervisor, working within a community mental health team, asked staff what came to mind when this term was used and staff associated this with clients typically diagnosed with ‘borderline personality disorder’.

Furthermore, in order to clarify this further, on both the information sheets and during the preamble to the interview participants were asked to reflect on working with clients with these types of difficulties. It was made explicit that their clients did not have to have a formal diagnosis, but that clients with this diagnosis may exhibit these types of difficulties.

Having utilised this throughout my project I have since reflected on whether this terminology adequately describes the experiences of clients and whether this would be viewed as less stigmatizing. Although, the intention was to avoid using diagnostic terminology, I wondered whether this terminology was any better as it is still defining a difficulty, essentially constraining an individuals' experiences. This terminology also neglects a number of experiences often present with this client group, such as difficulties with emotional regulation or self image, but more importantly fails to consider what experiences are meaningful for service users with these difficulties. In retrospect, this would have been an ideal opportunity to incorporate service user involvement in this project, consulting with those who have these difficulties to consider whether this term would be more appealing than diagnostic language.

Interestingly, while conducting the interviews I found myself shifting between the above phrase and the diagnostic terminology I had been adamant to avoid. I was aware of the contrast of terminology between myself and participants and found myself adopting the language used by staff during some interviews in order to have a shared understanding of their experiences. Given, constructivist grounded theory advocates the adoption of participants' views as reality (Charmaz, 2006), it was important to show I was 'hearing' what they were saying, acknowledging their understanding and beliefs and not forcing my own beliefs on others. However, I felt

conflicted internally and began to reflect on my own values and beliefs about the appropriateness of challenging diagnosis. This transferred into my clinical practice and I considered, whilst working on placement within a community mental health team, when it is appropriate to challenge a dominant medical perspective and when to adopt acceptance and show an awareness of the impact of shared language.

*Naming the phenomenon: is it compassion fatigue?*

The idea for this project came from anecdotal observations by my supervisor about the loss and maintenance of compassion in community mental health professionals working with this client group. During this conceptualisation we had a number of discussions about how to define this experience. We discussed whether the term “empathy fatigue” captured this or whether “compassion fatigue” worked better. After a number of conversations with my supervisors I decided to adopt the term ‘compassion fatigue’ in my research documents in order to help ground the reader to the basic premise of the study. At the time, I understood this term to mean a difficulty in accessing compassion towards others. Indeed, Rossi et al (2012) states compassion fatigue can be defined as a “reduced capacity or interest in being empathic” (p. 933), with empathy considered as a core component of compassionate relating (Gilbert, 2005). However, being a relative novice to the area of compassion fatigue I found the literature base surrounding this terminology confusing with authors offering conflicting definitions, with some relating this to a generic loss of empathy (Rossi et al, 2012) and others relating this to an emotional reaction specific to working with clients who have experienced trauma (Figley, 1995). I was also aware that within my proposed analysis strategy of grounded theory there is an encouragement to avoid heavy literature searching so not to bias results (Charmaz, 2006). Thus, I went with the term “compassion fatigue”.

Participants appeared to understand what I meant by this term, indeed, it did not interfere with recruitment and I offered an explanation at the beginning of every interview as to what the project was concerned with. However, as I began to interview staff and searched the literature a little more I realised this term did not fully capture the phenomenon I was researching, nor was it an accurate reflection. I discussed this further in supervision and agreed to consider an amendment to the project documents should this become an issue.

Given this did not present any issues for recruitment I did not make an amendment to any of the ethical documents. However, I was conscious that the terminology used in my ethics documents would not be consistent with my write up, despite the focus of the project remaining unchanged, and consequently felt it was important to discuss this within my critical appraisal. Through reflecting on the research process I have noticed the contrast between my urge to quantify staff's experience (i.e. to use terminology such as 'compassion fatigue') and my reluctance to do this with service users (i.e. use diagnostic terminology). I have since wondered whether the strength of my beliefs around diagnosis allowed me to challenge standard practices within research with regard to diagnostic terminology but perhaps I felt less confident in challenging this initially with regard to 'compassion fatigue'. However, from participating in the organic process that is inherent in qualitative research (Soefer, 1999) I feel confident about avoiding this terminology in the write up of the research paper as it does not fully represent the phenomenon studied.

### **Extending the study findings**

*What might happen when staff can't access a reflective space?*

As previously noted all participants within this grounded theory informed project were able to access a reflective space should they encounter challenges. Thus,

this project did not consider what might happen should the reflective space be unavailable. However, participants alluded to a number of possible outcomes. One possibility is that without a reflective space the uphill struggle would become a continual process that increases in intensity, with participants experiencing challenges within their clinical work and becoming more frustrated and exhausted as time passed. This could also lead to an increasing amount of negative attributions and, as discussed in the empirical paper, may have consequences related to burnout (Maslach & Jackson, 1982).

A further possibility involves staff ending their relationship with the client, with only one participant reflecting on this within the interviews. Beth described how she struggled to re-engage with her compassionate stance and requested a change of care coordinator for a client with whom she had been working, and alluded to viewing this as being compassionate for herself and the client. One also wonders if ending the relationship arose as a way to manage or escape feelings of frustration. One could speculate as to why this was; it may be that Beth had already experienced the uphill struggle-accessing a reflective space-adopting a compassionate stance cycle numerous times but for some reason on the latest occasion she could not regain her compassionate stance. Although, the reason for this is unknown it may be that staff have a threshold as to how many times this process could occur before it becomes too difficult to work compassionately with a client. Additionally, it might be that an element of this process was missing, such as a lack of understanding about the client and their behaviour. Or perhaps the shame present in admitting to a loss of compassion (see below), may also impact the ability for clinicians to end their relationship with the client. I wondered if admitting a need to quit was difficult for participants and prompted feelings of shame and guilt. Although the reflective space

goes some way to de-shame participants' sense of inadequacy, it perhaps does not translate to conversations with management about caseload.

Further research could consider what happens when staff are unable to access a reflective space and indeed whether this continual process would lead to burnout or staff leaving their posts with the team. However, it is likely recruitment of this sample would prove difficult due to the probability these clinicians may be off sick or no longer working within the service due to stress.

#### *The relationship between burnout and compassion*

Reflecting on the literature on burnout, and the conceptualisation of this according to Maslach (1982), has led me to consider the similarities between burnout as a concept and the process described by staff in 'the uphill struggle', albeit, perhaps to a lesser extent. In describing 'the uphill struggle' staff spoke about feeling deflated and frustrated from putting in lots of effort but it never being enough. This is perhaps akin to emotional exhaustion (a state of fatigue with depleted emotional capacity, Maslach & Jackson, 1981), and perhaps provides some insight into how this state occurs within staff. Furthermore the attributional process described in this model could be related to the depersonalisation construct discussed by Maslach (1982) (where staff hold negative and often derogatory views about clients) and feeling valued may relate to having a sense of personal accomplishment. Thus the model proposed in this thesis would suggest that emotional exhaustion occurs as a result of the challenges faced by staff working with clients with complex or challenging interpersonal difficulties, which activates the negative perceptions held about clients (depersonalisation). These, it appears, can be combatted by a sense of value (personal accomplishment) or importantly for this model, through accessing a reflective space which soothe, validates and empowers participants. There has been little research into



the relationship between compassion and burnout, which would be worthy of future research. As previously mentioned, one of the central conceptual categories in re-engaging with compassion was the importance of accessing a reflective space. This is further apparent in relation to burnout where staff with greater levels of workplace support reported lower levels of emotional exhaustion (Acker, 2003; Acker & Lawrence, 2009; Evans et al., 2006). Thus, perhaps one of the mechanisms by which staff are protected from burnout is through the utilisation of colleagues.

Having considered the potential presence of burnout within the model derived from participants, I wondered about the level of burnout participants were experiencing or had experienced in the past. None of the 11 participants objectively appeared to be experiencing burnout or suggested this themselves. Instead they spoke about times when they had faced challenges, which had impacted on their ability to adopt or re-engage with their compassionate stance, but discussed ways they had overcome this. Perhaps it would have been beneficial to have asked participants to complete the Maslach Burnout Inventory (Maslach & Jackson, 1981) in order to note whether the sample used in this project were collectively experiencing high levels of burnout. It would have then been interesting to compare these scores across interviews, noting any differences in the presence of certain focused codes, particularly those relating to the category 'an uphill struggle'.

#### *The importance of setting?*

Both the literature review and research project described in this thesis focused on staff within community based services. Research has highlighted the differences between the sources of stress within inpatient and community staff (Edwards, Burnard, Coyle, Fothergill & Hannigan, 2000) with some suggesting higher levels of stress and burnout in community based professionals (Carson, Leary, de Villiers,

Fagin & Radmall, 1995; Prosser, 1996). Little is known about compassion within acute psychiatry. Crawford, Gilbert, Gilbert, Gale and Harvey (2013) consider the discourses present within inpatient settings, noting a lack of compassionate language. It would be interesting to consider whether this model has applicability to staff within inpatient settings. Indeed, one could speculate as to the difficulty for staff in accessing a reflective space on the ward due to staffing and time pressures. Indeed, in discussing losses of compassion Anna, who had worked previously in inpatient units, noted:

I find it more in inpatient just because you're spending so much more time with the individual, whereas in the community you see somebody for an hour or whatever and you're able to remove yourself from that situation, come back, come out and reflect. Whereas in inpatient setting it's more intense because you don't always have the opportunity to take yourself out of that situation, you're constantly faced with that person and you don't have time to reflect.

Although it is reported that professionals working in inpatient services have lower levels of burnout (Carson, et al. 1995; Prosser, 1996) it would be interesting to consider whether staff similarly face difficulties engaging in a compassionate stance and what the facilitators or inhibitors of this are. Considering accessing a reflective space was key to community staff's ability to regain compassion, further research could determine the extent to which this is relevant for staff working within inpatient settings.

### **Reflecting on the presence of compassion**

#### *Searching for the right thesis*

I was first interested in the conceptualisation of compassion when I worked as a research assistant prior to clinical training; some of my psychologist colleagues

were considering the link between self-compassion and psychosis and it sparked my interest in the research of compassion within mental health. Once on training I began to further my learning about compassion and compassion focused therapy, through teaching, placement and conferences. I was fortunate on my adult placement to have a supervisor who incorporated this model into her practice and I began to use it within my own work and in my professional life.

My interest in this specific project came from attendance at a one day conference in compassion focused therapy where my field supervisor presented a poster about an exploratory price of work she had conducted in exploring compassion within community mental health teams. Having worked with my field supervisor when I was an assistant, I approached her about expanding her ideas into a thesis. Initially, we considered whether to conduct a quantitative piece of work to consider the relationship between compassion to others, working with clients with complex needs, self compassion and shame. However, after much reflection and, given my own preference, I decided to consider this from a qualitative perspective that enabled me to encapsulate the process behind this phenomenon.

#### *Building a personal relationship with compassion*

Throughout the process of conducting and writing this thesis I have been attending a compassionate mind training group facilitated by the university. This group has encouraged me to consider the use of compassion based techniques within my personal life, bridging the gap from personal to professional, and has helped me to self soothe at times when my own 'threat system' (Gilbert, 2005) has been activated (e.g. receiving feedback on drafts). I also identified with a number of the strategies offered by participants in managing challenges, most notably the use of a reflective space. Whilst on placement my supervisor has been continually

supportive, offering a safe and reflective space to consider not only placement issues but the expression of concerns regarding the thesis process.

*Hiding an absence of compassion*

Participants spoke about their desire to disengage with their clients as a result of the uphill struggle and consequently a difficulty in maintaining compassion. However, admitting to a loss of compassion was at times difficult. On occasion participants initially responded with denial to a direct question, however, as the interview progressed participants began to admit times where they had lost compassion and spoke about their thoughts and feelings quite openly. For some, admitting to a loss was accepting human fallibility and was treated with self compassion, whereas for others a self critical response ensued. On reflection I considered whether staff experienced shame or guilt in admitting to a loss, perhaps because of a fear around the judgements I would make. For some the choice of words was difficult and the societal expectation on mental health professionals to be compassionate clouded their ability to accept this;

Because society expects nurses to be very compassionate and you can't, you don't always manage to sustain that compassion towards people, especially with the media saying that nurses aren't very compassionate at the moment (Anna).

This comment by Anna led me to further reflect on the impact of current discourses around compassion within the UK. Indeed, there are a number of articles pertaining to the presence, or lack thereof, of compassion with mental health. Some are academic pieces written with the intent to promote the cultivation of compassion (Mclure, 2013) whereas others consider service user accounts detailing the experience of being on the receiving end of an absence of compassion (Lockhart, 2014). The National

Health Service (NHS) places compassionate care at the heart of their policies (Department of Health, 2013), in order to improve service users experience of health services. Indeed, this is a valid and important perspective. However, I began to wonder whether the presence of discussions around compassionate care in the media would lead staff to internalise a message that they were not being compassionate. I wondered whether this added to the pressures they already faced and cultivated the opinion that a loss of compassion was unacceptable, rather than placing emphasis on it as common but with a focus on managing and reflecting on this. I reflected on this further in the following memo:

*Current discourses promote the consistent and constant maintenance of compassion no matter what is going on personally, systemically or professionally for the individual. This led me to consider how important beliefs about compassion in the healthcare system are- both from within and externally. If one of the factors that facilitate a return to compassion for staff is being able to reflect on their experiences and discuss this in supervision, one begins to think about the impact of a blaming and shaming culture that doesn't provide the safe space for staff to freely express their feelings. This consequently might mean staff keep these feelings contained within, with no means of expression, which could a) detrimentally effect the well being of the professional b) negatively effect the therapeutic relationship, clients care and staffs willingness to engage with clients c) lead to a viscous circle concerning the transference of these emotions and d) in an extreme case lead to a permanent loss of compassion which may have consequences on staff burnout or compassion fatigue.*

*Participant- Researcher interface*

When participants were discussing some of the negative attributions in relation to their experience with clients it felt in conflict with my own perspective regarding mental health, and in adopting a recovery focused person centred approach. I began to notice feeling less compassionate towards staff members myself, as documented in my reflective journal:

*“Had an interview today with participant from [team removed]. Found it quite difficult as she was very blaming and negative towards the client. It felt like she really didn’t understand the client and I wondered how the client must feel in their interactions. I found myself getting quite frustrated with her and what she was telling me. I wonder what this is this about? Perhaps my own judgements were coming out about how I think staff should behave?”*

It was important when analysing this particular interview I ensured I was not judgemental in my coding. Given I adopted a social constructivist epistemological stance, which disregards the presence of a universal truth and instead views truth to lie within the experiences of an individual (Charmaz, 2006), it was important I validated the appraisals shared by the participant as her reality. In order to help do this I ensured I continued to utilise my reflective journal to explore my own feelings about this experience and discussed my analysis in supervision.

With an awareness of my own judgements I reflected on the judgements that may be made of me by my examiners. In particular, I noticed my reluctance to label these attributions described by participants as ‘negative’ on the model. In exploring this, my supervisor and I reflected on whether I was trying to dampen this aspect of the model, hiding from the word negative, so my examiners would not think I was not being compassionate towards the participants I interviewed. By discussing my concerns in supervision they were validated, enabling me to overcome this worry and

name this category in a way that best reflected what it entailed. In essence, this process mirrors what participants may have felt during the interviews in admitting to a loss of compassion, and also in perhaps asking for a change in care coordinator due to the feared shaming response by others.

### **Conclusion**

This critical appraisal has commented on the process behind conducting a project investigating the loss and maintenance of compassion in community mental health staff. It has considered the use of terminology, and the interaction of this with my own values and beliefs, as well offering an extension of the study findings. This appraisal has also provided space to reflect on the presence of compassion within my own personal life and the research process.

### References

- Acker, G. (2003). Role conflict and ambiguity. *Social Work in Mental Health, 1, 3*, 63-80.
- Acker, G. & Lawrence, D. (2009). Social work and managed care: Measuring competence, burnout and role stress of workers providing mental health services in a manager care era. *Journal of Social Work, 9, 3*, 269-283.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders*. (5th ed.) Washington DC, USA: American Psychiatric Association.
- Boyle, M. (2007). The problem with diagnosis. *The Psychologist, 20*, 290-292.
- Carey, T. (2013). *Science Media Centre DSM-5 press briefing: Comments from research and clinical professionals*. (Online article). Retrieved from <http://dxrevisionwatch.com/tag/peter-kinderman/>
- Carson J., Leary J., de Villiers N., Fagin L. & Radmall J. (1995) Stress in mental health nurses: Comparison of ward and community staff. *British Journal of Nursing 4*, 579–581.
- Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. London, UK: Sage.
- Crawford, P., Gilbert, P., Gilbert, J., Gale, C. & Harvey, K. (2013). The Language of Compassion in Acute Mental Health care. *Qualitative Health Research, 23*, 719-727.
- Department of Health. (2013). The NHS Constitution for England. Retrieved from [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/170656/NHS\\_Constitution.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf)



- Division of Clinical Psychology (2013). Division of Clinical Psychology Position Statement on the Classification of Behaviour and Experience in Relation to Functional Psychiatric Diagnoses: Time for a Paradigm Shift (online article). Retrieved from: <http://dxrevisionwatch.files.wordpress.com/2013/05/position-statement-on-diagnosis-master-doc.pdf>.
- Edwards, D. Burnard, P., Fothergill, A. & Hannigan, B. (2000). Stress and burnout in community mental health nursing: a review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 7, 7–14.
- Evans, S., Huxley, P., Gatley, C., Webber, M., Mears, A., Pajak, S. et al. (2006). Mental health, burnout and job satisfaction among mental health social workers in England and Wales. *British Journal of Psychiatry*, 188, 75-80.
- Figley, C.R. (1995). *Compassion Fatigue: Coping With Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York, USA: Brunner/Mazel.
- Gilbert, P. (2005) *Compassion: Conceptualisations, Research and Use in Psychotherapy*. London, UK: Routledge.
- Horn, N., Johnstone, L., & Brooke, S. (2007). Some service user perspectives on the diagnosis of borderline personality disorder. *Journal of Mental Health*, 16, 2, 255-269.
- Kinderman, P., Read, J., Moncrieff, J. & Bentall, R. P. (2013). Drop the language of disorder. *Evidence Based Mental Health*, 16, 2-3.
- Mason, T., Caulfield, M., Hall, R., & Melling, K. (2010). Perceptions of diagnostic labels in forensic psychiatric practice: A survey of differences between nurses and other disciplines. *Issues in Mental Health Nursing*, 31, 336-344.

- Maslach, C. (1982). *Burnout: The cost of caring*. Englewood Cliffs, USA: Prentice Hall.
- Maslach, C., & Jackson, S.E. (1981). The measurement of experienced burnout. *Journal of Occupational Behavior*, 2, 99-113.
- McLure, R. (2013). Sustaining compassion in health care. (Online article). Retrieved from [http://greatergood.berkeley.edu/article/item/sustaining\\_compassion\\_in\\_health\\_care](http://greatergood.berkeley.edu/article/item/sustaining_compassion_in_health_care)).
- Lockhart, L. (2014). Is modern treatment of mental health lacking compassion? (Online article) Retrieved from <http://www.mentalhealthy.co.uk/news/862-modern-treatment-of-mental-health-lacking-compassion.html>.
- Kendell, R. & Jablensky, A. (2003). Distinguishing between the validity and utility of psychiatric diagnoses, *American Journal of Psychiatry*, 160, 4-12.
- Pilgrim, D. (2013). *Science Media Centre DSM-5 press briefing: Comments from research and clinical professionals*. (Online article). Retrieved from <http://dxrevisionwatch.com/tag/peter-kinderman/>
- Prosser D. (1996). Mental health, burnout and job satisfaction among hospital and community-based mental health staff. *British Journal of Psychiatry*, 169, 3, 328-337.
- Rossi et al. (2012). Burnout, Compassion Fatigue and Compassion Satisfaction among staff in community-based mental health services. *Psychiatry Research*, 200, 933-938.
- Slade, M. & Priebe, S. (2001). Are randomised controlled trials the only gold that glitters? *British Journal of Psychiatry*, 179, 286-287.
- Soefer, S. (1999). Qualitative methods: what are they and why use them? *Health Services Research*, 34, 5, 1101-1118.

Wykes, T. (2013). *Science Media Centre DSM-5 press briefing: Comments from research and clinical professionals*. (Online article). Retrieved from <http://dxrevisionwatch.com/tag/peter-kinderman/>

**Section Four: Ethics Section**

The process underpinning staff's loss and maintenance of compassion towards clients  
with complex or challenging interpersonal difficulties

**Word Count: 4769**

Rachel Wass (nee Watts)

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

**All correspondence should be sent to:**

Rachel Wass (nee Watts)  
Doctorate in Clinical Psychology  
Furness College  
Lancaster University  
Lancaster  
LA1 4YT  
[r.watts@lancaster.ac.uk](mailto:r.watts@lancaster.ac.uk)

## Research Protocol

**Title:** Staff's experience of working with clients with complex or challenging interpersonal difficulties: compassion fatigue and the psychological processes underpinning it.

**Applicant:** Rachel Watts

**Academic Supervisor:** Dr Fiona Eccles

**Field Supervisors:** Dr Zoe Rivers

### Summary

This qualitative research project hopes to understand staff's experience of compassion fatigue when working with clients with complex or challenging interpersonal difficulties. Participants will be invited to take part in the project if they currently work within a secondary care community mental health team (CMHT) or personality disorder service. All interviews will then be transcribed and analysed using grounded theory.

### Introduction

Staff working in community based mental health teams support a number of clients with varying mental health needs. This may include clients with complex personalities who have typically been diagnosed with Borderline Personality Disorder (BPD). BPD is a diagnostic term given to clients who tend to find it difficult to manage their emotions and struggle to maintain positive social relationships (MIND, 2012).

Recent research has explored the attitudes of professionals working with clients with personality difficulties. Research suggests staff tend to hold a negative view of this client group (Commons Treloar & Lewis, 2008; Bowers & Allan, 2006; Potter, 2006), with professional background and gender significantly contributing to the level of negativity. For instance, female staff and those from an allied health professional discipline (psychologist, occupational therapy and social work) report fewer negative attitudes compared to male staff from a medical or nursing background (Commons Treloar & Lewis, 2008).

Working with clients with personality difficulties can be highly stressful for mental health professionals, notably due to the nature of the difficulties experienced by this client group (Ohaeri, 2003). Indeed, evidence suggests high rates of burnout in this population of staff (Rossi et al. 2012). It has also been suggested that staff can, on occasion, display low levels of compassion and empathy to those clients who repeatedly present to services in distress or at risk of self harm (Rayner et al. 2005). This reduction in a capacity to show compassion or empathy for the difficulties experienced by clients is often described as compassion fatigue (Figley, 1995). Compassion fatigue has been described as an "occupational hazard" (Rossi et al. 2012: 933) for those who work within a mental health context, specifically in community based services. Compassion fatigue can be defined as a "reduced capacity or interest in being empathic" (Rossi et al. 2012: 933), which is often accompanied by anxiety, preoccupation, irritability, avoidance and on occasion intrusive imagery

(Rossi et al. 2012; Figley, 1995, 2002b; Wright, 2004).

Research has highlighted the many correlates of compassion fatigue. For example, increased hours of working, high client case load (Boscarino et al., 2004; Sprang et al. 2007) and a personal history of trauma (Cunningham, 2003) all relate to higher levels of compassion fatigue in staff, whereas years of professional experience are associated with lower levels of compassion fatigue (Cunningham, 2003). Preliminary evidence suggests self-compassion could play a role in helping staff to manage the difficulties of working with complex clients (Rivers 2012).

At present the majority of studies investigating staff experiences of compassion fatigue have focussed on the medical profession and psychotherapists. Austin, Goble, Leier and Byrne (2009) interviewed medical and psychiatric nurses about their experience of compassion fatigue, citing this as leading to a change in practice, negative feelings and feelings of hopelessness. Similar themes were identified in the experience of compassion fatigue in genetic counselors (Benoit, McCarthy & LeRoy, 2007).

### **Rational and aims for the current project**

Although the evidence base for the existence of compassion fatigue and its correlates is extensive there is little research considering the experience compassion fatigue. Currently, there is no research exploring this phenomenon and the processes underpinning this within a mental health context. Given the pressures faced by community based mental health staff working with complex clients (Ohaeri, 2003; Rossi et al. 2012), it would seem important to develop our understanding of this. Furthermore, it is anticipated that this project will also have implications for therapeutic interventions with staff in order to decrease the likelihood of compassion fatigue and to increase staff well being. In addition, it will add to the psychological knowledge of understanding the experience of compassion fatigue, the process underpinning it in staff and the difficulties faced by them.

### **Design**

A qualitative approach will be implemented within this project with participants consenting to a 60-minute (approximately) semi structured interview. All participants will be asked to consent to the interview being audio recorded and to complete a demographic information sheet. Participants will be interviewed at their place of work, a local health centre or their home, depending on preference.

### **Participants**

Participants will continue to be recruited until data saturation occurs. It is anticipated this will occur between 10 and 15 participants. Staff currently based within a CMHT or personality disorder service will be eligible to take part in this project. The inclusion criteria for this project also includes the following:

- Staff must have or have had contact with clients within the last 2 years who have 'complex or challenging interpersonal difficulties', who may or may not have been diagnosed as having personality disorder.
- Staff who have a nursing, social work or occupational therapy professional background. This may also include staff with a variety of job titles such as care coordinator and senior practitioner.
- Be willing to discuss experiences of compassion fatigue.

Furthermore, participants must be able to provide written consent, speak English and be based within the north-west region to increase ease of interviewing.

### **Procedure**

All health professionals (as stated above) working in a community mental health team (CMHT) or personality disorder service will be invited to take part in the project. Contact will be made with staff via team leaders or previously established contacts to facilitate recruitment. Depending on the preference of the team this may include circulating an email with the participant information sheet attached or presenting the project at team meetings. If necessary prompt emails will also be sent following initial contact. Posters and leaflets will also be made available at the intended recruitment sites. The researcher will also attend special interest groups, case formulation meetings and training events to advertise the research should the occasion arise.

Staff interested in the project will be asked to contact the researcher via email or telephone to discuss the project further. At this point the researcher will answer any questions potential participants have about the project, check participant eligibility and arrange a time to conduct the interview should participants wish to take part. Interviews will be conducted at a time convenient for the participant. The interview may be conducted over 1 or 2 sessions depending on the preference of the participant and researcher. It may be that after the interview the researcher would like to follow up on an aspect discussed and may contact the participant again to consider this further, with the participant's consent.

### **Practical Issues**

If participants choose to be interviewed at their place of work the researcher will ensure this is conducted in a private room to preserve confidentiality. Should participants wish to be interviewed at a local health centre rather than at their home or work travel expenses will be reimbursed up to £10. Lancaster University will cover other potential costs such as printing, photocopying and travel expenses for the researcher. A further practical issue is the potential for low recruitment numbers. R&D approval from additional NHS trusts will be sought should recruitment prove difficult in the lead site.

### **Ethical Concerns**

#### *Confidentiality and Data Protection*

All interviews will remain strictly confidential, unless concerns around safety are raised during the interview. These concerns may involve risk to the participant or risk to other people. Where this is the case, this information will be shared with the appropriate person. Where concerns are raised regarding professional practice the researcher will seek supervision from the project field or academic supervisor. Any instances requiring action will be discussed with the participant, where possible, and the appropriate people informed.

Following the interview, the researcher will transcribe the data collected, creating an anonymised transcript. This will be done within 3 months of meeting with the participant. The audio recording will be removed from the portable device and stored as an encrypted file on the university server. This will be done within 24 hours of the interview. Once the thesis is submitted and assessed, the audio file will be destroyed.

These anonymised transcripts will be kept electronically on the university server. The researcher's academic supervisor will have access to this raw data. In order to protect participant confidentiality the field supervisor will not have access to raw data but will be involved in the later stages of the analysis and write up. Following completion of the study they will be stored securely at the university for 5 years from publication, up to a maximum of 10 years.

Consent forms will be stored securely at Lancaster University and kept for 5 years from publication, up to a maximum of 10 years. If participants contact the researcher via email, this email will be stored in a separate inbox on a password protected email account. If participants contact the researcher by phone participant contact details will be recorded on an initial contact detail sheet and stored electronically on a password protected computer. On completion of data collection contact information gained via email will be transferred onto an initial contact detail sheet. All contact detail sheets will then be stored securely at Lancaster University for 12 months to allow the researcher to send a newsletter to the participants containing results from the study once analysis and write up has been completed. Following this 12-month period, or before if the project is disseminated prior to this date, all contact information sheets will be destroyed.

#### *Participant Distress*

Although it is not anticipated, participants may experience distress from the interviews. If this is the case the researcher will use the appropriate clinical skills to help manage this distress. Following the interview, participants will be given a debrief sheet detailing the recommended action should distress occur or continue following the interview.

#### *Safety of the researcher*

Participants may prefer to meet in their own home to participate in the interview. Where this is the case the researcher will follow the Lancashire Care NHS Trust lone worker policy and Lancaster University lone worker policy.

#### **Proposed Analysis**

Data transcripts will be analysed using a constructivist grounded theory approach. Constructivist grounded theory approaches adopt a relativist perspective on experience, suggesting the absence of an objective truth, but rather accept the possibility of many subjective truths (Mills, Bonner & Francis, 2006). After each interview the researcher will transcribe the data and then follow the guidelines detailed by Charmaz (2006) for the analytic process. This process is both iterative and interactive. Firstly, researchers are advised to code their data (using both initial and more focused coding) and to constantly make comparisons between the created codes and the data they were generated from (Charmaz, 2006). From these codes a psychological theory of the phenomenon investigated is developed, which is again constantly compared with data and the codes it was generated from (Charmaz 2006). As interviewing continues this generated theory is evaluated and revised, with new codes informing this. Questioning during the interviews will also change as the data takes the researcher in new directions. At theoretical saturation, interviews cease and the developed theory is revised, further integrating memos and refining concepts (Charmaz, 2006).



**Timescale**

<b>Date</b>	<b>Task</b>
April-May 2013	Apply and gain ethical approval
June-September 2013	Collect data Transcribe and analyse interviews
October-January 2014	Complete draft write up
February-March 2014	Amend paper based on feedback
April-May 2014	Submit

### References

- Austin, W., Goble, E., Leier, B. & Byrne, P. (2009). Compassion Fatigue: The Experience of Nurses. *Ethics and Social Welfare*, 3, 2, 195-214. doi: 10.1080/17496530902951988.
- Benoit, L. G., McCarthy Veach, P. & LeRoy, B. S. (2007). When You Care Enough to Do Your Very Best: Genetic Counselor Experiences of Compassion Fatigue. *Journal of Genetic Counseling*, 16, 3, 299-312. doi: 10.1007/s10897-006-9072-1.
- Bowers, L., & Allan, T. (2006). The attitudes to personality disorder questionnaire: psychometric properties and results. *Journal of Personality Disorders*, 20, 3, 281-293. doi: 10.1521/pedi.2006.20.3.281.
- Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London, UK: Sage.
- Commons Treloar, A. J., & Lewis, A. J. (2008). Professional attitudes towards deliberate self-harm in patients with borderline personality disorder. *Australian and New Zealand Journal of Psychiatry*, 42, 7, 578-584. doi: 10.1080/0004867080 2119796.
- Cunningham, M. (2003). Impact of trauma work on social work clinicians: empirical findings. *Social work*, 48, 4, 451-459. doi: 10.1093/sw/48.4.451.
- Figley, C.R. (1995). *Compassion Fatigue: Coping With Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York, USA: Brunner/Mazel.
- Figley, C.R. (2002b). *Treating Compassion Fatigue*. New York, USA: Brunner-Routledge.

- MIND. (2012). *Understanding Borderline Personality Disorder*. London, UK: National Association for Mental Health. Retrieved from [http://www.mind.org.uk/mental\\_health\\_az/8037\\_understanding\\_borderline\\_personality\\_disorder](http://www.mind.org.uk/mental_health_az/8037_understanding_borderline_personality_disorder).
- Mills, J., Bonner, A. & Francis, K. (2006). The Development of Constructivist Grounded Theory. *International Journal of Qualitative Methods*, 5, 1, 1-10.
- Ohaeri J.U. (2003). The burden of caregiving in families with a mental illness: a review of 2002. *Current Opinion in Psychiatry*, 16, 457-465. doi: 10.1097/01.yco.0000079212.36371.c0.
- Potter, N. (2006). What is manipulative behaviour, anyway? *Journal of Personality Disorders*, 20, 2, 139-156. doi: 10.1521/pedi.2006.20.2.139.
- Rivers, Z. (2012, October) *The impact of working with complex personalities and trauma in secondary care- compassion fatigue and burnout: an affect regulation approach*. Poster presented at the Clinical Applications of Compassion Focused Therapy (CFT) conference.
- Rossi et al. (2012). Burnout, Compassion Fatigue and Compassion Satisfaction among staff in community-based mental health services. *Psychiatry Research*, 200, 933-938. doi: 10.1016/j.psychres.2012.07.029.
- Wright, B. (2004) Compassion Fatigue: how to avoid it. *Palliative Medicine*, 18, 4-5. doi: 10.1191/0269216304pm866ed.



**Faculty of Health and Medicine Research Ethics Committee (FHMREC)  
Lancaster University**

**Application for Ethical Approval for Research**

Instructions

1. Apply to the committee by submitting
  - ✓ The University's Stage 1 Self-Assessment Form (standard form or student form) **and** the Project Information & Ethics questionnaire. These are available on the Research Support Office website: [LU Ethics](#)
  - ✓ The completed FHMREC application form
  - ✓ Your full research proposal (background, literature review, methodology/methods, ethical considerations)
  - ✓ All accompanying research materials such as, but not limited to,
    - 1) Advertising materials (posters, e-mails)
    - 2) Letters of invitation to participate
    - 3) Participant information sheets
    - 4) Consent forms
    - 5) Questionnaires, surveys, demographic sheets
    - 6) Interview schedules, interview question guides, focus group scripts
    - 7) Debriefing sheets, resource lists
2. Submit all the materials electronically as a **SINGLE** email attachment in PDF format. Instructions for creating such a document are available on the FHMREC website (<http://www.lancs.ac.uk/shm/research/ethics/>).
3. Submit one collated and signed paper copy of the full application materials. If the applicant is a student, the paper copy of the application form must be signed by the Academic Supervisor.
4. Committee meeting dates and application submission dates are listed on the research ethics committee website <http://www.lancs.ac.uk/shm/research/ethics/>. Applications must be submitted by the deadline stated on the website, to:
 

Bethan McMullen  
Faculty of Health & Medicine  
B04, Furness College  
Lancaster University, LA1 4YD  
[b.mcmullen@lancaster.ac.uk](mailto:b.mcmullen@lancaster.ac.uk)
5. Attend the committee meeting on the day that the application is considered.

<p>1. Title of Project:</p> <p>Staff experience of working with clients with complex or challenging interpersonal difficulties: compassion fatigue and the psychological processes underpinning it.</p>
<p>2. If this is a student project, please indicate what type of project by ticking the relevant box:</p> <p> <input type="checkbox"/> PG Diploma                <input type="checkbox"/> Masters dissertation                <input type="checkbox"/> MRes                <input type="checkbox"/> MSc                <input type="checkbox"/> DClintPsy            SRP         </p>

<input type="checkbox"/> PhD Thesis <input type="checkbox"/> PhD Pall. Care/Pub. Hlth/Org. Hlth & Well Being <input type="checkbox"/> MD <input checked="" type="checkbox"/> DClinPsy Thesis <input type="checkbox"/> Special Study Module (3 <sup>rd</sup> year medical student)
3. Type of study <input checked="" type="checkbox"/> Involves direct involvement by human subjects <input type="checkbox"/> Involves existing documents/data only. Contact the Chair of FHMREC before continuing.

<b>Applicant information</b>
4. Name of applicant/researcher:  Rachel Watts
5. Appointment/position held by applicant and Division within FHM  Trainee Clinical Psychologist (Doctorate in Clinical Psychology, Division of Health Research)
6. Contact information for applicant:  E-mail: r.watts@lancaster.ac.uk Telephone: 01524 592970  Address: Doctorate in Clinical Psychology, Division of Health Research, Lancaster University, Lancaster, LA1 4YT
7. Project supervisor(s), if different from applicant:  Name(s): Dr XXXX      Email: XXXXXX Dr XXXX      Email: XXXXXX
8. Appointment held by supervisor(s) and institution(s) where based (if applicable):  Dr Fiona Eccles: Lecturer in Research methods, Lancaster University.  Dr Zoe Rivers: Clinical Psychologist with Greater Manchester West Mental Health NHS Foundation Trust. Based at Ramsgate House Community Mental Health Team.
9. Names and appointments of all members of the research team (including degree where applicable)  Rachel Watts- Principle Researcher (Trainee Clinical Psychologist, Lancaster University) Dr XXXXXX- Academic Supervisor (Lecturer in Research Methods, Lancaster University) Dr XXXXXX- Field Supervisor (Clinical Psychologist, XXXXXXXX)

<b>The Project</b>  NOTE: In addition to completing this form you must submit a detailed research protocol and all supporting materials.
10. Summary of research protocol in lay terms (maximum length 150 words).  Working with clients with complex personalities can be highly stressful for mental health professionals (Ohaeri, 2003), with high rates of burnout evident (Rossi et al. 2012). It has also been suggested that staff can, on occasion, display low levels of compassion and empathy to those clients who repeatedly present to services in distress or at risk of self-

harm (Rayner et al. 2005). This reduction in a desire to show compassion or empathy for the difficulties experienced by clients is often described as compassion fatigue (Figley, 1995). This qualitative research project hopes to understand staff's experience of compassion fatigue when working with clients with 'interpersonal difficulties' and the process underpinning this experience. Participants will be invited to take part in the project if they currently work within a secondary care community mental health team (CMHT) or personality disorder service. All interviews will then be transcribed and analysed using grounded theory.

The researcher is using the terms 'complex or challenging interpersonal difficulties' rather than borderline personality disorder to reflect the growing consensus in psychological literature pertaining to the utility, validity and reliability of such a diagnostic label (Harper, 2001; Stalker et al. 2005; Shaw & Proctor 2005). This term was deemed less stigmatizing and reflected the researcher's preference to avoid engaging in a medical perspective of mental health and in labelling individuals. A preliminary face validity test, in conjunction with advice from my supervisor, suggests staff will understand this terminology and I am confident this would not impact on my recruitment. However, further details are contained within the participant information sheet and on the research advertisement indicating this term often refers to the behaviour exhibited by people who may or may not have been diagnosed with a borderline personality disorder, which may be a more familiar term to staff. Borderline personality disorder is a diagnostic term given to clients who tend to find it difficult to manage their emotions and struggle to maintain positive social relationships (MIND, 2012). Participants' clients do not have to have a clinical diagnosis of borderline personality disorder, as it is the client's presentation and the participant's perception of this that is important for this project. The researcher will make every effort to ensure participants understand the terms used within the project by engaging in discussions with participants prior to any interviews.

11. Anticipated project dates

Start date: May 2013    End date: June 2014

12. Please describe the sample of participants to be studied (including number, age, gender):

Staff currently based within a CMHT or personality disorder service will be eligible to take part in this project if they meet the following criteria:

- Staff must have or have had contact with clients within the last 2 years who have 'interpersonal difficulties', who may or may not have been diagnosed as having borderline personality disorder.
- Staff who have a nursing, social work or occupational therapy professional background. This may include staff with a variety of job titles such as care co-ordinator and senior practitioner.
- Be willing to discuss experiences of compassion fatigue.

Furthermore, participants must be able to provide written consent, speak English and be based within the north-west region to increase ease of interviewing. Psychologists and psychiatrists are not eligible to take part in the project.

13. How will participants be recruited and from where? Be as specific as possible.

Health professionals from a nursing, social work or occupational therapy background working in any community mental health team (CMHT) or personality disorder service within the NHS trust recruitment site will be invited to take part in the project. Contact will be made with staff via team leaders or previously established contacts to facilitate recruitment. Depending on the preference of the team this may include circulating an email with the participant information sheet attached or presenting the project at team meetings. If necessary prompt emails will also be sent following initial contact. Posters and leaflets will also be made available at intended recruitment sites. The researcher will also attend special interest groups, case formulation meetings and training events to advertise

<p>the research should the occasion arise. Staff interested in the project will be asked to contact the researcher via email or telephone to discuss the project further. At this point the researcher will answer any questions potential participants have about the project, check participant eligibility and arrange a time to conduct the interview should participants wish to take part.</p>
<p>14. What procedure is proposed for obtaining consent?</p> <p>All participants will be given a participant information sheet detailing the research project to ensure they are well informed about the project prior to participation. The researcher will also ensure there is an opportunity to answer any questions. All participants will be asked to sign a consent form at the time of interview.</p> <p>Participants may withdraw their data from the project up to 2 weeks following the interview by contacting the researcher directly. Any information gained from this participant will then be destroyed.</p>
<p>15. What discomfort (including psychological), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks.</p> <p>Although discomfort, inconvenience or danger as a result of the interview is not anticipated, it is possible that some questions may touch on sensitive topics that could distress participants. When this is the case the researcher will use her clinical skills to manage any situations of distress that arise. This will give the participants the opportunity to discuss any issues that have arisen from the interview. If necessary the researcher will seek further supervision from the project supervisors. Participants will also be advised to speak to their line managers, occupational health, their GP or to seek professional help should distress continue. This recommended course of action will be detailed in the debrief sheet.</p> <p>Some participants may find the interview burdening due to the length of time it may take, however all participants will be offered breaks throughout to minimise the chance of this. The interview is expected to take one hour.</p>
<p>16. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, details of a lone worker plan).</p> <p>There are minimal potential risks to the researcher. If participants wish to be seen in their own home the researcher will follow the Lancashire Care NHS and Lancaster University Lone Worker policy. This will involve the researcher having a charged mobile phone on her, having pre-planned the route to the interview location and utilising a buddy system, if necessary. This will involve the researcher informing a colleague of the location of the interview and an expected departure time. In the event the researcher does not leave at the expected time, the colleague will ring the researcher to confirm safety. If the colleague is unsuccessful in contacting the researcher after several attempts the police will be called.</p>
<p>17. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.</p> <p>There are no direct benefits for participants but it is hoped that taking part in the research will help to further our understanding of the pressures faced by staff and may also have implications for future staff support groups aimed at improving well-being.</p>
<p>18. Details of any incentives/payments (including out-of-pocket expenses) made to participants:</p> <p>If participants wish to meet at a local health centre rather than their place of work or home address travel expenses will be paid by Lancaster University, up to a maximum of £10</p>



on production of receipts or a completed mileage claim form.
<p>19. Briefly describe your data collection and analysis methods, and the rationale for their use</p> <p>Constructivist grounded theory approaches adopt a relativist perspective on experience, suggesting the absence of an objective truth, but rather accept the possibility of many subjective truths (Mills, Bonner &amp; Francis, 2006). After each interview the researcher will transcribe the data and then follow the guidelines detailed by Charmaz (2006) for the analytic process. This process is both iterative and interactive. Firstly, researchers are advised to code their data (using both initial and more focused coding) and to constantly make comparisons between the created codes created and the data they were generated from (Charmaz, 2006). From these codes a psychological theory of the phenomenon investigated is developed, which is again constantly compared with data and the codes it was generated from (Charmaz 2006). As interviewing continues this generated theory is evaluated and revised, with new codes informing this. Questioning during the interviews will also change as the data takes the researcher in new directions. At theoretical saturation, interviews cease and the developed theory is revised, further integrating memos and refining concepts (Charmaz, 2006).</p>
<p>20. Describe the involvement of users/service users in the design and conduct of your research. If you have not involved users/service users in developing your research protocol, please indicate this and provide a brief rationale/explanation.</p> <p>The study proposal was presented to fellow doctorate clinical psychology trainees, service users and members of the doctorate in clinical psychology research team. At this presentation the project, including potential barriers and solutions were discussed. The proposal was then revised according to the feedback given.</p>
<p>21. What plan is in place for the storage of data (electronic, digital, paper, etc.)? Please ensure that your plans comply with the Data Protection Act 1998.</p> <p>Consent forms will be stored securely at Lancaster University and kept for for 5 years from publication, up to a maximum of 10 years. If participants contact the researcher via email, this email will be stored in a separate inbox on a password protected email account. If participants contact the researcher by phone participant contact details will be recorded on an initial contact detail sheet and stored electronically on the university server. On completion of data collection contact information gained via email will be transferred onto an initial contact detail sheet. All contact detail sheets will then be stored securely at Lancaster University for 12 months to allow the researcher to send a newsletter to the participants containing results from the study once analysis and write up has been completed. Following this 12-month period, or before if the project is disseminated prior to this date, all contact information sheets will be destroyed. The contact details will be kept separate so they cannot be matched with other participant data.</p>
<p>22. Will audio or video recording take place?    <input type="checkbox"/> no            <input checked="" type="checkbox"/> audio            <input type="checkbox"/> video  If yes, what arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?</p> <p>With consent from the participant all interviews will be audio-recorded. Until the transcript has been anonymised the audio recording will be removed from the portable device and stored as an encrypted file on the University server. Once the thesis is submitted and assessed, the audio file will be destroyed. This will be done within 3 months of meeting with the participant. These anonymised transcripts will then be kept electronically on the university server whilst analysis is undertaken. The researcher's academic supervisor will have access to this raw data. In order to protect participant confidentiality the field</p>



<p>supervisor will not have access to raw data but will be involved in the later stages of the analysis and write up. Following completion of the study they will be stored securely at the university for 5 years from publication, up to a maximum of 10 years, and then destroyed. The academic supervisor for the project, Dr XXXXXXX, will be custodian of the data and administrative staff for the Doctorate in Clinical Psychology will be responsible for destroying the data after the required time period.</p>
<p>23. What are the plans for dissemination of findings from the research?</p> <p>The research will be written up in part completion of the Doctorate in Clinical Psychology at Lancaster University. The researcher also hopes to publish the research in a peer reviewed journal and disseminate the findings to the participants. Furthermore, the project will be presented at a Doctorate in Clinical Psychology presentation day.</p>
<p>24. What particular ethical problems, not previously noted on this application, do you think there are in the proposed study?</p> <p>All interviews will remain strictly confidential, unless concerns around safety are raised during the interview. These concerns may involve risk to the participant or risk to other people. Where this is the case, this information will be shared with the appropriate person. A further consideration may involve confidentiality with regard to the professional practice of participants. For example, if participants discuss their experiences detailing their own actions, although unlikely, there is the possibility that this may give rise to concern regarding professional practice. Where concerns are raised the researcher will seek supervision from the project field or academic supervisor. Any instances requiring action will be discussed with the participant, when possible, and the appropriate action taken.</p> <p>Staff who wish to be interviewed on work premises will be informed there may be a chance their colleagues may infer they are taking part in the project if seen speaking with the researcher. However, the researcher will be explicit that the location of the interview is the participant's choice. If participants still choose to be interviewed on work premises every attempt will be made to ensure confidentiality. The researcher will attempt to interview the staff member in a room away from the service's team office and in a quiet location, to reduce the chance of other staff becoming aware of their participation. Any confidential information given during the interview will be suitably anonymised in preparation for thesis submission and publication. Therefore, if someone knew that a particular participant took part they would be unable to identify what they said during the interview.</p>

Signatures:                      Applicant:  
 .....

Date:  
 .....

Project Supervisor\* (if applicable):  
 .....

Date:  
 .....

\*I have reviewed this application, and discussed it with the applicant. I confirm that the project methodology is appropriate. I am happy for this application to proceed to ethical review.

NHS R&amp;D Form

IRAS Version 3.5

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

**Please enter a short title for this project** (maximum 70 characters)  
Staff experience of compassion fatigue

**1. Is your project research?**

Yes  No

**2. Select one category from the list below:**

- Clinical trial of an investigational medicinal product
- Clinical investigation or other study of a medical device
- Combined trial of an investigational medicinal product and an investigational medical device
- Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
- Basic science study involving procedures with human participants
- Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
- Study involving qualitative methods only
- Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
- Study limited to working with data (specific project only)
- Research tissue bank
- Research database

**If your work does not fit any of these categories, select the option below:**

Other study

**2a. Please answer the following question(s):**

- a) Does the study involve the use of any ionising radiation?  Yes  No
- b) Will you be taking new human tissue samples (or other human biological samples)?  Yes  No
- c) Will you be using existing human tissue samples (or other human biological samples)?  Yes  No

**3. In which countries of the UK will the research sites be located?** *(Tick all that apply)*

- England
- Scotland
- Wales
- Northern Ireland

**3a. In which country of the UK will the lead NHS R&D office be located:**

NHS R&amp;D Form

IRAS Version 3.5

- England  
 Scotland  
 Wales  
 Northern Ireland  
 This study does not involve the NHS

**4. Which review bodies are you applying to?**

- NHS/HSC Research and Development offices  
 Social Care Research Ethics Committee  
 Research Ethics Committee  
 National Information Governance Board for Health and Social Care (NIGB)  
 National Offender Management Service (NOMS) (Prisons & Probation)

*For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.*

**It looks like your project is research requiring NHS R&D approval but does not require review by a REC within the UK Health Departments Research Ethics Service – is that right?**

- Yes    No

**4b. Please confirm the reason(s) why the project does not require review by a REC within the UK Health Departments Research Ethics Service:**

- Projects limited to the use of samples/data samples provided by a Research Tissue Bank (RTB) with generic ethical approval from a REC, in accordance with the conditions of approval.  
 Projects limited to the use of data provided by a Research Database with generic ethical approval from a REC, in accordance with the conditions of approval.  
 Research limited to use of previously collected, non-identifiable information  
 Research limited to use of previously collected, non-identifiable tissue samples within terms of donor consent  
 Research limited to use of acellular material  
 Research limited to use of the premises or facilities of care organisations (no involvement of patients/service users as participants)  
 Research limited to involvement of staff as participants (no involvement of patients/service users as participants)

**5. Will any research sites in this study be NHS organisations?**

- Yes    No

**5a. Are all the research costs and infrastructure costs for this study provided by an NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC) or NIHR Research Centre for Patient Safety & Service Quality in all study sites?**

- Yes    No

*If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP).*

**5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) support and inclusion in the NIHR Clinical Research Network (CRN) Portfolio? Please see information button for further details.**

- Yes    No

NHS R&amp;D Form

IRAS Version 3.5

*If yes, NHS permission for your study will be processed through the NIHR Coordinated System for gaining NHS Permission (NIHR CSP) and you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form immediately after completing this project filter and before completing and submitting other applications.*

**6. Do you plan to include any participants who are children?**

Yes  No

**7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?**

Yes  No

*Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.*

**8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?**

Yes  No

**9. Is the study or any part of it being undertaken as an educational project?**

Yes  No

Please describe briefly the involvement of the student(s):  
The study is being undertaken as part completion for a Doctorate in Clinical Psychology.

**9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?**

Yes  No

**10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?**

Yes  No

**11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?**

Yes  No

NHS R&amp;D Form

IRAS Version 3.5

---

**Integrated Research Application System**  
**Application Form for Research involving qualitative methods only**


---

**NHS/HSC R&D Form (project information)**

Please refer to the *Submission and Checklist* tabs for instructions on submitting R&D applications.

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting [Help](#).

Please define any terms or acronyms that might not be familiar to lay reviewers of the application.

**Short title and version number:** (maximum 70 characters - this will be inserted as header on all forms)  
 Staff experience of compassion fatigue

**PART A: Core study information**
**1. ADMINISTRATIVE DETAILS**
**A1. Full title of the research:**

Staff experience of working with clients with complex or challenging interpersonal difficulties: compassion fatigue and the psychological processes underpinning it.

**A2-1. Educational projects**

Name and contact details of student(s):

**Student 1**

	Title	Forename/Initials	Surname
	Miss	Rachel	Watts
Address	Furness Building Lancaster University Lancaster		
Post Code	LA1 4YG		
E-mail	r.watts@lancaster.ac.uk		
Telephone	07908613784		
Fax			

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:  
 Doctorate in Clinical Psychology

Name of educational establishment:  
 Lancaster University

Name and contact details of academic supervisor(s):

**Academic supervisor 1**

NHS R&amp;D Form

IRAS Version 3.5

	Title Forename/Initials Surname
Address	Furness Building Lancaster University Lancaster
Post Code	LA1 4YG
E-mail	
Telephone	01524 592807
Fax	

Please state which academic supervisor(s) has responsibility for which student(s):  
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Miss Rachel Watts	

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

#### A2-2. Who will act as Chief Investigator for this study?

- Student  
 Academic supervisor  
 Other

#### A3-1. Chief Investigator:

	Title Forename/Initials Surname
	Miss R S Watts
Post	Trainee Clinical Psychologist
Qualifications	BSc Dual Hons Psychology and Sociology MRes Psychology
Employer	Lancashire Care Mental Health NHS Foundation Trust
Work Address	Furness Building Lancaster University Lancaster
Post Code	LA1 4YG
Work E-mail	r.watts@lancaster.ac.uk
* Personal E-mail	
Work Telephone	07908613784
* Personal Telephone/Mobile	
Fax	

\* This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.  
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

#### A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?

NHS R&amp;D Form

IRAS Version 3.5

This contact will receive copies of all correspondence from REC and R&D reviewers that is sent to the CI.

	Title Forename/Initials Surname
Address	Research Support Office, University House Lancaster University, Bailrigg Lancaster
Post Code	LA1 4YW
E-mail	ethics@lancaster.ac.uk
Telephone	01524592605
Fax	01524843087

**A5-1. Research reference numbers.** Please give any relevant references for your study:

Applicant's/organisation's own reference number, e.g. R & D (if available):  
 Sponsor's/protocol number:  
 Protocol Version: 2  
 Protocol Date: 20/05/2013  
 Funder's reference number:  
 Project website:

**Additional reference number(s):**

Ref.Number	Description	Reference Number
------------	-------------	------------------

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

**A5-2. Is this application linked to a previous study or another current application?**

Yes  No

Please give brief details and reference numbers.

**2. OVERVIEW OF THE RESEARCH**

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

**A6-1. Summary of the study.** Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, this summary will be published on the website of the National Research Ethics Service following the ethical review.

Working with clients with complex or challenging interpersonal difficulties, can be highly stressful for mental health professionals (Ohaeri, 2003), with high rates of burnout evident (Rossi et al. 2012). It has also been suggested that staff can, on occasion, display low levels of compassion and empathy to those clients who repeatedly present to services in distress or at risk of self-harm (Rayner et al. 2005). This reduction in a desire to show compassion or empathy for the difficulties experienced by clients is often described as compassion fatigue (Figley, 1995). This qualitative research project hopes to understand staff's experience of compassion fatigue when working with clients with interpersonal difficulties. Participants will be invited to take part in the project if they currently work within a



NHS R&amp;D Form

IRAS Version 3.5

secondary care community mental health team (CMHT) or personality disorder service. All interviews will then be transcribed and analysed using grounded theory.

**A6-2. Summary of main issues.** Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.

*Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.*

Although it is not anticipated that the interview will lead to distress, some questions may touch on information that could be distressing to some participants. Many participants often welcome the chance to share their experiences but if distress is encountered the chief investigator will draw on her clinical experience to manage this distress. This will include giving the participants the opportunity to discuss any issues that have arisen from the interview. If necessary the chief investigator will seek further supervision from the project supervisors. Participants will also be advised to speak to their line managers, occupational health, their GP or to seek professional help should distress continue. Recommended action for seeking help will be provided in the debrief sheet.

Some participants may find the interview burdening due to the length of time it may take, however all participants will be offered breaks throughout to minimise the chance of this.

### 3. PURPOSE AND DESIGN OF THE RESEARCH

**A7. Select the appropriate methodology description for this research.** Please tick all that apply:

- Case series/ case note review
- Case control
- Cohort observation
- Controlled trial without randomisation
- Cross-sectional study
- Database analysis
- Epidemiology
- Feasibility/ pilot study
- Laboratory study
- Metanalysis
- Qualitative research
- Questionnaire, interview or observation study
- Randomised controlled trial
- Other (please specify)

**A10. What is the principal research question/objective?** Please put this in language comprehensible to a lay person.

1. What are staff's experience of compassion fatigue and the psychological process underpinning this?

**A11. What are the secondary research questions/objectives if applicable?** Please put this in language comprehensible to a lay person.

1. To understand the process by which compassion fatigue may occur.
2. To understand the impacts of compassion fatigue.
3. To highlight ways to help staff manage this experience.

**A12. What is the scientific justification for the research?** Please put this in language comprehensible to a lay person.



NHS R&amp;D Form

IRAS Version 3.5

Staff working in community based mental health teams support a number of clients with varying mental health needs. This may include clients with interpersonal difficulties who have typically been diagnosed with Borderline Personality Disorder (BPD). BPD is a diagnostic term given to clients who tend to find it difficult to manage their emotions and struggle to maintain positive social relationships (MIND, 2012).

The pressures of working with clients with complex or challenging interpersonal difficulties is widely documented, with research suggesting this work can be highly stressful (Ohaeri, 2003). Furthermore, evidence highlights high levels of staff burnout and low levels of compassion and empathy to those service users who repeatedly present at services in distress or at risk of self harm (Rossi et al. 2012; Rayner et al. 2005). This reduction in a desire to show compassion or empathy for the difficulties experienced by clients is often described as compassion fatigue (Figley, 1995) and has been described as an "occupational hazard" (Rossi et al. 2012: 933) for those who work within a mental health context, specifically in community based services.

Although there is much evidence citing the correlates of compassion fatigue, such as increased hours of working, high client case load (Boscarino et al., 2004; Sprang et al. 2007) and a personal history of trauma (Cunningham, 2003), there is very little research understanding staff's experience of this. The research that does exist focuses on the medical profession, rather than staff based in a mental health setting.

Given the pressures faced by community based mental health staff working with clients with 'personality difficulties' it is plausible to argue for the need to develop our understanding of this within this cohort of staff. Understanding the process by which compassion fatigue occurs and staff's experience of this may help to inform staff support interventions aimed at decreasing the likelihood of compassion fatigue and increasing staff well being. Qualitative methodology is the optimum way to explore the experience of a given phenomenon and is used increasingly within psychological research.

**A13. Please summarise your design and methodology.** *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

#### Design

This project is a qualitative study aimed at understanding staff's experience of compassion fatigue.

The chief investigator hopes to interview staff members about their experience of working with clients with complex or challenging interpersonal difficulties and the occurrence of compassion fatigue. Participants will continue to be recruited until data saturation occurs. It is anticipated this will occur between 10 and 15 participants. Staff currently based within a CMHT or personality disorder service will be eligible to take part in this project. The inclusion criteria for this project also includes the following:

- Staff must have or have had contact with clients within the last 2 years who have complex or challenging interpersonal difficulties, who may or may not have been diagnosed as having borderline personality disorder.
- Staff who have a nursing, social work or occupational therapy professional background, which may also include care coordinators and senior practitioners.
- Be willing to discuss experiences of compassion fatigue.

Furthermore, participants must be able to provide written consent, speak English and be based within the north-west region to increase ease of interviewing.

#### Recruitment

Health professionals who meet the above criteria and work in a community mental health team (CMHT) or personality disorder service will be invited to take part in the project. Contact will be made with staff via team leaders or previously established contacts. Depending on the preference of the team this may include circulating an email with the participant information sheet attached or presenting the project at team meetings. If necessary prompt emails will also be sent following initial contact. Posters and leaflets will also be made available at the intended recruitment sites. The researcher will also attend special interest groups, case formulation meetings and training events to advertise the research should the occasion arise.

Staff interested in the project will be asked to contact the researcher via email or telephone to discuss the project further. At this point the researcher will answer any questions potential participants have about the project, check participant eligibility and arrange a time to conduct the interview should participants wish to take part.

#### Procedure

Staff who express an interest in taking part will be asked to choose where they would prefer to be interviewed by the chief investigator. This could be at their place of work, home or at a local health centre. Before the interview starts the chief investigator will check the participant has read the information sheet and has had enough time to consider whether they wish to take part. If the participant is happy to continue they will be asked to sign a consent form. The interview will last approximately 60 minutes, with the opportunity for breaks throughout. The interview may be conducted over 1 or 2 sessions depending on the preference of the participant and researcher. It may be that after the

NHS R&amp;D Form

IRAS Version 3.5

interview the researcher would like to follow up on aspects discussed and may contact the participant again to consider this further, with the participants consent. Throughout and following the interview the chief investigator will check the participant is not distressed. Should distress arise the chief investigator will discuss this with the participant acting accordingly. All participants will be given a leaflet detailing the recommended action should they require further support following the interview.

**Analysis**

Interviews will be transcribed and anonymised, removing all identifiable personal data. The transcripts will then be analysed using Grounded Theory as detailed by Charmaz (2006). This process will involve input from the chief investigator's supervisors to ensure identified themes are an accurate reflection of the data collected and to increase scientific credibility.

**A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?**

- Design of the research
- Management of the research
- Undertaking the research
- Analysis of results
- Dissemination of findings
- None of the above

*Give details of involvement, or if none please justify the absence of involvement.*

A member of the Lancaster University Public Involvement Network reviewed the proposed research and suggested ways the proposal could be improved. Following these discussions changes were made to the study design.

#### 4. RISKS AND ETHICAL ISSUES

##### RESEARCH PARTICIPANTS

**A15. What is the sample group or cohort to be studied in this research?**

Select all that apply:

- Blood
- Cancer
- Cardiovascular
- Congenital Disorders
- Dementias and Neurodegenerative Diseases
- Diabetes
- Ear
- Eye
- Generic Health Relevance
- Infection
- Inflammatory and Immune System
- Injuries and Accidents
- Mental Health
- Metabolic and Endocrine
- Musculoskeletal
- Neurological
- Oral and Gastrointestinal

NHS R&amp;D Form

IHAS Version 3.5

- Paediatrics  
 Renal and Urogenital  
 Reproductive Health and Childbirth  
 Respiratory  
 Skin  
 Stroke

Gender: Male and female participants

Lower age limit: 18 Years

Upper age limit: No upper age limit

**A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).**

1. Staff must have or have had contact with clients within the last 2 years who have complex or challenging interpersonal difficulties, who may or may not have been diagnosed as having borderline personality disorder.
2. Staff who have a nursing, social work or occupational therapy professional background, which may include care coordinators and senior practitioners.
3. Be willing to discuss experiences of compassion fatigue.

Furthermore, participants must be able to provide written consent, speak English and be based within the north-west region to increase ease of interviewing.

**A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).**

1. Staff who do not have a background in one of the above professions.

**RESEARCH PROCEDURES, RISKS AND BENEFITS**

**A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. These include seeking consent, interviews, non-clinical observations and use of questionnaires.**

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Invitation to participate in the study.	3	n/a	10 mins	Chief investigator, invitations via colleagues and attendance at meetings.
Reading the participant information sheet.	1	n/a	15mins	Participant to read this in own time and at a pace of their choice.
Email or telephone contact to determine eligibility and arrange interview	1	n/a	10mins	The chief investigator will discuss this with the participant via telephone or email.
Obtain informed consent	1	n/a	10	Chief investigator, at the participants work place, home or local health center.
Face to face interviews	1	n/a	60 mins	Chief investigator, at the participants work place, home or local health center.

**A21. How long do you expect each participant to be in the study in total?**

NHS R&amp;D Form

IRAS Version 3.5

This will be roughly 2 hours depending on how long the interview lasts. This may vary with each participant.

**A22. What are the potential risks and burdens for research participants and how will you minimise them?**

*For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.*

Although distress is not expected, steps will be taken to resolve this distress should it occur. The chief investigator will discuss any concerns with the participant and give them the opportunity to talk through any distress, utilising her own clinical skills. If necessary the chief investigator will seek further supervision from the project supervisors who have experience working with staff. Additionally, all participants will be given information detailing the recommended action should distress continue and further support is needed following the interview.

The interviews are scheduled to take 60 minutes, which may be burdensome to some participants. The chief investigator will try to lessen this burden by offering participants the opportunity to have a break during the interview.

**A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?**

Yes  No

*If Yes, please give details of procedures in place to deal with these issues:*

Some topics discussed in the interview may be distressing to participants however steps will be taken to appropriately address any distress experienced. The chief investigator will monitor participants distress levels throughout the interview and discuss any distress with the participant should it occur. Furthermore, information regarding the recommended action should distress continue will be provided to participants.

It will be made explicit that participants do not have to respond to any question they do not wish to answer and that they have the right to withdraw from the research at any point during the interview and up to 2 weeks after the interview has taken place. Furthermore, the researcher will explain that participants will be able to take breaks throughout the interview.

If disclosures requiring action are made they will be discussed with the project supervisor. The chief investigator or the project supervisor will then take the appropriate steps. Participants will be informed that all information given during the interview will be confidential with the exception of information concerning the participants safety or that of another. In the rare occasion where confidentiality must be broken the chief investigator will discuss this with the client where possible. Where concerns are raised regarding professional practice the researcher will seek supervision from the project supervisors. Any instances requiring action will be discussed with the participant, where possible, and the appropriate people informed.

**A24. What is the potential for benefit to research participants?**

There are no direct benefits for participants but it is hoped that taking part in the research will help to further our understanding of the pressure faced by staff and may also have implications for future staff support groups aimed at improving well being.

**A26. What are the potential risks for the researchers themselves? (if any)**

The chief investigator will meet with participants at either their place of work, home or local health center. This will be the participants choice. However, some risks may be present when seeing participants in their own home. This will be addressed by following the lone worker guidance contained in Lancaster University's Guidance on safety in fieldwork document (<http://www.lancs.ac.uk/depts/safety/files/fieldguidance.pdf>) and Lancashire Care NHS Trust lone worker policy.

**RECRUITMENT AND INFORMED CONSENT**

*In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.*



NHS R&amp;D Form

IRAS Version 3.5

**A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?** For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).

Staff working within a community mental health team or personality disorder service will be invited to take part in the project if they have a background in nursing, social work or occupational therapy. Potential participants will hear about the project via their team leader or a previously established contact. This may involve the team leader (or appropriate person) circulating an email with the participant information sheet attached to all staff. Alternatively staff may hear about the project via the researchers attendance at any team meetings, case formulations, special interest groups, conferences or training events. Posters and leaflets will also be left at intended recruitment sites with the permission of the service. Potential participants expressing an interest in the project will be asked to contact the researcher (either via email or telephone) to discuss the project further. At this point the researcher will answer any questions potential participants have about the project, check participant eligibility and arrange a time to conduct the interview should participants wish to take part.

**A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?**

Yes  No

Please give details below:

**A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?**

Yes  No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

Posters and leaflets will be left at the intended recruitment sites. The researcher will also attend (if invited) any team meetings, case formulation meetings, special interest groups, conferences and training events to advertise the project.

**A29. How and by whom will potential participants first be approached?**

The potential participants will be approached in one of two ways. If the researcher or the researchers supervisor presents the project at any team meetings, case formulation meetings, special interest groups, conferences and training events then the participants will be initially approached by the researcher, or her supervisor. However, attendance at any service meetings will be with the permission of the appropriate person within the team (e.g. team leader) and organised in conjunction with this person.

Potential participants will also be invited to take part in the project via email (with the participant information sheet attached). This will be arranged by the researcher with a member of the team who will send this information on behalf of the researcher. This will ensure the researcher does not have access to any contact details of staff without their consent.

**A30-1. Will you obtain informed consent from or on behalf of research participants?**

Yes  No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

A participant information sheet will be given to all potential participants. Interested participants will be asked to contact the researcher via email or telephone. The researcher will then check participant eligibility, answer any questions, gain contact details and arrange an interview should the participant wish to take part in the project. If participants wish to take part in the research then prior to the interview participants will be asked by the chief investigator to sign and complete an informed consent sheet.

NHS R&amp;D Form

IRAS Version 3.5

*If you are not obtaining consent, please explain why not.*

*Please enclose a copy of the information sheet(s) and consent form(s).*

**A30-2. Will you record informed consent (or advice from consultees) in writing?**

Yes  No

**A31. How long will you allow potential participants to decide whether or not to take part?**

A minimum of 24 hours.

**A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?(e.g. translation, use of interpreters)**

Unfortunately funding is not available for translating services. However, it is likely that staff working within these services will have an understanding of both verbal and written English.

**A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? Tick one option only.**

- The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.
- The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.
- The participant would continue to be included in the study.
- Not applicable – informed consent will not be sought from any participants in this research.
- Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

*Further details:*

If participants lose capacity during the interview their data will not be used. If, during the 2 week period of withdrawal, the researcher becomes aware a participant has lost the ability to consent their data will be withdrawn.

#### CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

#### Storage and use of personal data during the study

**A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?(Tick as appropriate)**

- Access to medical records by those outside the direct healthcare team
- Electronic transfer by magnetic or optical media, email or computer networks
- Sharing of personal data with other organisations
- Export of personal data outside the EEA
- Use of personal addresses, postcodes, faxes, emails or telephone numbers
- Publication of direct quotations from respondents
- Publication of data that might allow identification of individuals

NHS R&amp;D Form

IRAS Version 3.5

- Use of audio/visual recording devices
- Storage of personal data on any of the following:
- Manual files including X-rays
  - NHS computers
  - Home or other personal computers
  - University computers
  - Private company computers
  - Laptop computers

**Further details:**

Use of emails or telephone numbers.

Participants will be asked to contact the researcher via email or telephone should they express an interest in taking part in the project. These details will then be kept in order for the researcher to arrange an interview, should the participant wish to take part. During the study this information will be stored electronically on Lancaster University's server and any emails will be stored in a separate inbox on a password protected email account. On completion of data collection it will be stored securely at Lancaster University for up to 12 months. This information will be kept so that the researcher can contact the participant to send out a summary of the results of the project following completion.

Publication of direct quotations:

Quotations may be used from the interviews but these will be anonymised and any identifiable data will be removed.

Use of audio recording:

All interviews will be recorded. Anonymised transcripts will then be created within 3 months of the interview. These anonymised transcripts will be kept securely on Lancaster University's server during analysis. Following this they will be stored securely at Lancaster University. The audio recordings will be removed from the portable device within 24 hours following the interview and stored as encrypted files on Lancaster University's server until transcription is complete. Once the thesis is submitted and assessed the audio recording will be destroyed.

**A37. Please describe the physical security arrangements for storage of personal data during the study?**

Prior to the interview participants will be required to sign a consent form that has their name on. Consent forms will be kept securely at Lancaster University.

During the study contact details will be stored electronically on the university server or if contact is made via email on a separate inbox on a password protected email account. Following completion of data collection personal data will be stored at Lancaster University.

All interviews will be recorded on an audio device and then transcribed within 3 months of the interview taking place. Following the interview the audio recording will be removed from the portable device and stored securely on Lancaster University's server during the transcription process. These transcriptions will be anonymised and all identifiable data will be removed. Once the thesis is submitted and assessed the audio recording will be destroyed. Anonymised transcripts will be stored on Lancaster University's server during the study and then stored securely at Lancaster University following the study.

**A38. How will you ensure the confidentiality of personal data? Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.**

All transcripts will be anonymised and any identifiable data will be removed. Pseudonyms for the participants will be used to report the results of the project. These anonymised transcripts, participant consent forms and any contact details will be kept securely at Lancaster University to comply with codes set out by the University for storing data, following completion of the study.

**A40. Who will have access to participants' personal data during the study? Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.**

No-one other than the Chief Investigator will have access to personal data such as participant's name and contact details. The chief investigator and the academic supervisor will have access to the anonymised transcripts. The field

NHS R&amp;D Form

IRAS Version 3.5

supervisor will only be involved in later stages of analysis in order to protect participant confidentiality and anonymity. Participants will be aware of this as this is documented in the participant information sheet.

#### Storage and use of data after the end of the study

##### A41. Where will the data generated by the study be analysed and by whom?

Once the interviews have been transcribed the anonymised transcripts will be kept securely on Lancaster University's server. The chief investigator will conduct the analysis, although the academic supervisors may see the transcript and aid analysis to ensure credibility. On completion of the study the transcripts will be stored securely at Lancaster University.

##### A42. Who will have control of and act as the custodian for the data generated by the study?

	Title Forename/Initials Surname
	[REDACTED]
Post	Lecturer in Research Methods
Qualifications	
Work Address	Furness Building Lancaster University Lancaster
Post Code	LA1 4YG
Work Email	[REDACTED]
Work Telephone	01524 592807
Fax	

##### A43. How long will personal data be stored or accessed after the study has ended?

- Less than 3 months  
 3 – 6 months  
 6 – 12 months  
 12 months – 3 years  
 Over 3 years

##### A44. For how long will you store research data generated by the study?

Years: 10  
Months:

##### A45. Please give details of the long term arrangements for storage of research data after the study has ended. Say where data will be stored, who will have access and the arrangements to ensure security.

The research data (consent form and anonymised transcript) will be stored securely at Lancaster University. Only the research director for the course, the course administrator, the chief investigator and her academic supervisor will have access to this data. This data will be stored for 5 years from publication, up to a maximum of 10 years.

#### INCENTIVES AND PAYMENTS



NHS R&amp;D Form

IRAS Version 3.5

**A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?**

Yes  No

*If Yes, please give details. For monetary payments, indicate how much and on what basis this has been determined. The participants will receive travel reimbursement, up to a maximum of £10 on production of receipts or a completed mileage claim form, if they choose to meet at a venue other than their own house or place of work.*

**A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?**

Yes  No

**A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?**

Yes  No

#### NOTIFICATION OF OTHER PROFESSIONALS

**A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?**

Yes  No

*If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.*

#### PUBLICATION AND DISSEMINATION

**A50. Will the research be registered on a public database?**

Yes  No

*Please give details, or justify if not registering the research. In the event the study is accepted for publication the abstract will be publicly available from the journals' website.*

*Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.*

**A51. How do you intend to report and disseminate the results of the study? Tick as appropriate:**

- Peer reviewed scientific journals
- Internal report
- Conference presentation
- Publication on website
- Other publication
- Submission to regulatory authorities
- Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators

NHS R&amp;D Form

IRAS Version 3.5

- No plans to report or disseminate the results  
 Other (please specify)

The research will be written up in part completion of the Doctorate in Clinical Psychology at Lancaster University. The chief investigator also hopes to publish the research in a peer reviewed journal. The project will be presented at a Doctorate in Clinical Psychology presentation day.

**A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?**

Identifiable data will not be used in any publication of the project. If quotations are used from the anonymised transcripts these will also be anonymised.

**A53. Will you inform participants of the results?**

- Yes  No

Please give details of how you will inform participants or justify if not doing so.  
 Participants will receive a summary of the project findings as participants details will be kept for up to 12 months.

**5. Scientific and Statistical Review**

**A54. How has the scientific quality of the research been assessed? Tick as appropriate:**

- Independent external review  
 Review within a company  
 Review within a multi-centre research group  
 Review within the Chief Investigator's institution or host organisation  
 Review within the research team  
 Review by educational supervisor  
 Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:

The study proposal was presented to fellow doctoral trainees, service users and two clinical tutors within the doctorate program. At this presentation potential difficulties and solutions for the proposed project were discussed. The proposal was then revised accordingly.

*For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.*

*For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.*

**A59. What is the sample size for the research? How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.**

Total UK sample size: 15  
 Total international sample size (including UK):  
 Total in European Economic Area:

**Further details:**

A maximum of 15 participants will be interviewed. However, it may be fewer should data saturation be reached prior to this.

**A60. How was the sample size decided upon? If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.**

NHS R&amp;D Form

IRAS Version 3.5

Published literature on qualitative methodology suggests an acceptable sample size of 10-15 participants for grounded theory informed analysis. As analysis and recruitment is an iterative, continuous process within this methodology it is hard to accurately say the number of participants interviewed. Interviews will cease on data saturation. The researcher anticipates this will occur after 10-15 interviews.

**A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.**

The interviews will be transcribed and analysed using a constructivist grounded theory approach such as that outlined by Charmaz (2006).

#### 6. MANAGEMENT OF THE RESEARCH

**A63. Other key investigators/collaborators. Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.**

	Title	Forename/Initials	Surname
	[REDACTED]		
Post	Clinical Psychologist		
Qualifications	Doctorate in Clinical Psychology		
Employer	[REDACTED]		
Work Address	[REDACTED]		
Post Code	[REDACTED]		
Telephone	[REDACTED]		
Fax	[REDACTED]		
Mobile	[REDACTED]		
Work Email	[REDACTED]		

#### A64. Details of research sponsor(s)

##### A64-1. Sponsor

###### Lead Sponsor

Status:  NHS or HSC care organisation

Academic

Pharmaceutical industry

Medical device industry

Local Authority

Other social care provider (including voluntary sector or private organisation)

Other

Commercial status:

*If Other, please specify:*

###### Contact person

Name of organisation Lancaster University

NHS R&amp;D Form

IRAS Version 3.5

Given name	[REDACTED]
Family name	[REDACTED]
Address	Research support office, university house, lancaster university
Town/city	Lancaster
Post code	LA1 4YW
Country	UNITED KINGDOM
Telephone	01524592805
Fax	01524843087
E-mail	ethics@lancaster.ac.uk

**Is the sponsor based outside the UK?**  
 Yes  No

*Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.*

**A65. Has external funding for the research been secured?**

Funding secured from one or more funders  
 External funding application to one or more funders in progress  
 No application for external funding will be made

What type of research project is this?

Standalone project  
 Project that is part of a programme grant  
 Project that is part of a Centre grant  
 Project that is part of a fellowship/ personal award/ research training award  
 Other

Other – please state:

**A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1)? Please give details of subcontractors if applicable.**

Yes  No

**A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?**

Yes  No

*Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.*

**A68-1. Give details of the lead NHS R&D contact for this research:**

Title Forename/Initials Surname  
 [REDACTED]

NHS R&amp;D Form

IRAS Version 3.5

Organisation Address  Post Code Work Email Telephone Fax Mobile	
Details can be obtained from the NHS R&D Forum website: <a href="http://www.rdforum.nhs.uk">http://www.rdforum.nhs.uk</a>	

**A69-1. How long do you expect the study to last in the UK?**

Planned start date: 27/05/2013  
 Planned end date: 02/06/2014  
 Total duration:  
 Years: 1 Months: 0 Days: 7

**A71-1. Is this study?**

- Single centre  
 Multicentre

**A71-2. Where will the research take place? (Tick as appropriate)**

- England  
 Scotland  
 Wales  
 Northern Ireland  
 Other countries in European Economic Area

Total UK sites in study

Does this trial involve countries outside the EU?

- Yes  No

**A72. What host organisations (NHS or other) in the UK will be responsible for the research sites? Please indicate the type of organisation by ticking the box and give approximate numbers of planned research sites:**

- NHS organisations in England 1  
 NHS organisations in Wales  
 NHS organisations in Scotland  
 HSC organisations in Northern Ireland  
 GP practices in England  
 GP practices in Wales  
 GP practices in Scotland  
 GP practices in Northern Ireland  
 Social care organisations  
 Phase 1 trial units

NHS R&amp;D Form

IRAS Version 3.5

- Prison establishments  
 Probation areas  
 Independent hospitals  
 Educational establishments  
 Independent research units  
 Other (give details)

Total UK sites in study: 1

**A73-1. Will potential participants be identified through any organisations other than the research sites listed above?**

- Yes  No

**A74. What arrangements are in place for monitoring and auditing the conduct of the research?**

As this project is in part completion of a doctoral training program the chief investigator will be supervised by both an academic and clinical supervisor. This will ensure appropriate conduct both on a research and clinical level.

**A76. Insurance/ indemnity to meet potential legal liabilities**

*Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland*

**A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? Please tick box(es) as applicable.**

*Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.*

- NHS indemnity scheme will apply (NHS sponsors only)  
 Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

**A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? Please tick box(es) as applicable.**

*Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.*

- NHS indemnity scheme will apply (protocol authors with NHS contracts only)  
 Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

**A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?**

NHS R&amp;D Form

IRAS Version 3.5

*Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.*

- NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)  
 Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

*Please enclose a copy of relevant documents.*

**A78. Could the research lead to the development of a new product/process or the generation of intellectual property?**

- Yes  No  Not sure

NHS R&amp;D Form

IRAS Version 3.5

**PART C: Overview of research sites**

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. For NHS sites, the host organisation is the Trust or Health Board. Where the research site is a primary care site, e.g. GP practice, please insert the host organisation (PCT or Health Board) in the Institution row and insert the research site (e.g. GP practice) in the Department row.

Research site	Investigator/ Collaborator/ Contact
Institution name	
Department name	
Street address	
Town/city	
Post Code	



## PART D: Declarations

**D1. Declaration by Chief Investigator**

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2008.
7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.
9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
  - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
  - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
  - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
  - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
  - May be sent by email to REC members.
10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
11. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

**Contact point for publication(Not applicable for R&D Forms)**

*NRES would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.*

- Chief Investigator
- Sponsor

NHS R&amp;D Form

IRAS Version 3.5

- Study co-ordinator
- Student
- Other – please give details
- None

**Access to application for training purposes** (*Not applicable for R&D Forms*)*Optional – please tick as appropriate:*

I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

Signature: .....

Print Name: Rachel Watts

Date: (dd/mm/yyyy)

NHS R&amp;D Form

IRAS Version 3.5

**D2. Declaration by the sponsor's representative**

*If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.*

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.
7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Signature: .....

Print Name:

Post:

Organisation:

Date: (dd/mm/yyyy)

NHS R&amp;D Form

IRAS Version 3.5

**D3. Declaration for student projects by academic supervisor(s)**

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.
2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.
3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.
4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

**Academic supervisor 1**

Signature: .....

Print Name:

Post:

Organisation:

Date: (dd/mm/yyyy)

## Appendix 4-A

## Sponsor Letter

Vice-Chancellor's  
OfficeLANCASTER  
UNIVERSITY

Applicant name: Rachel Watts  
Supervisor: Dr [REDACTED]  
Department: DHR

11 June 2013

Dear Rachel a [REDACTED]

**Re: Staff experience of working with clients with complex or challenging interpersonal difficulties: compassion fatigue and the psychological processes underpinning it**

The University of Lancaster undertakes to perform the role of sponsor in the matter of the work described in the accompanying grant application. The sponsor as we understand it assumes responsibility for monitoring and enforcement of research governance. As principal investigator you will confirm that the institution's obligations are met by ensuring that, before the research commences and during the full term of the grant, all the necessary legal and regulatory requirements in order to conduct the research are met, and all the necessary licenses and approvals have been obtained. The Institution has in place formal procedures for managing the process for obtaining any necessary or appropriate ethical approval for this grant. Full ethical approval must be in place before the research commences and should be reviewed at all relevant times during the grant.

Yours sincerely,

Professor [REDACTED]  
PVC Research,  
Chair, University Research Ethics Committee.

Cc [REDACTED] Secretary, UREC.

## Appendix 4-B

## University Ethics Approval Letter

Applicant: Rachel Watts  
Supervisor: [REDACTED]  
Department: DHR

LANCASTER  
UNIVERSITY



07 June 2013

Dear Rachel and [REDACTED]

**Re: Staff experience of working with clients with complex or challenging interpersonal difficulties: compassion fatigue and the psychological processes underpinning it**

Thank you for submitting your research ethics application for the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The application was recommended for approval by FHMREC, and on behalf of the Chair of the University Research Ethics Committee (UREC), I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact the Research Ethics Officer, Debbie Knight (01542 592605 [ethics@lancaster.ac.uk](mailto:ethics@lancaster.ac.uk)) if you have any queries or require further information.

Yours sincerely,

*S.C. Tange*

[REDACTED]  
Secretary, University Research Ethics Committee

Cc: [REDACTED] (Chair, UREC); Professor [REDACTED] (Chair, FHMREC)

Research Support Office  
Research and Enterprise Services

Lancaster University  
Bowland Main  
Lancaster LA1 4YT  
United Kingdom

Tel: +44 (0) 1524 592002  
Fax: +44 (0) 1524 593229  
Web: <http://www.lancs.ac.uk>



## Appendix 4-C

## R &amp; D Approval

**Standardised Process for  
Electronic Approval of Research**

8 July 2013

Miss Rachel Watts  
Furness Building  
Lancaster University  
Lancaster LA1 4YG

**Information for ID Badge if required:**

Research Project Ref No: 779  
Expiry Date: 31 July 2014

**You must take this letter with you.**

Dear Miss Watts

**Re: NHS Permission for Research**

**Project Reference: 779**  
**Unique SPEAR Identifier: 1229**  
**CSP Reference Number: N/A**  
**IRAS/REC Reference Number: 1229**  
**Sponsor: University of Lancaster**  
**Protocol Version and Date: Version 2.0, 20 May 2013**  
**Project Title: Staff's experience of working with clients with complex or  
challenging interpersonal difficulties: compassion fatigue and the  
psychological processes underpinning it.**  
**Date of Permission: 8 July 2013**

Further to your request for permission to conduct the above research study at this Trust, we are pleased to inform you that this Trust has given NHS permission for the research. **Your NHS permission to conduct research at this site is only valid upon receipt of a signed 'Conditions for NHS Permission Reply Slip' which is enclosed.**

Please take the time to read the attached conditions for NHS permission. Please contact the R&D Office should you require any further information. You will need this letter as proof of NHS permission. Please note when contacting the R&D office about your study you must always provide the project reference numbers provided above.

NHS permission for the above research has been granted on the basis described in the IRAS application form, Protocol and supporting documentation.

**The documents reviewed were:**

**Protocol: Version 2.0, 20 May 2013**  
**Participant Information Sheet: Version 2.0, 20 May 2013**  
**Participant Consent Form: Version 2.0, 20 May 2013**  
**R&D Form: 28 June 2013**  
**SSI Form: 28 June 2013**  
**REC letter giving favourable ethical opinion: N/A Staff only study**

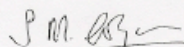
Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework and NHS Trust policies and procedures. Permission is only granted for the activities for which a favourable opinion has been given by the Ethics Committee.


Permission covers all locations within the Trust, however, you should ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing your research.

We would like to point out that hosting research studies incurs costs for the Trust such as: staff time, usage of rooms, arrangements for governance of research. We can confirm that in this instance we will not charge for these. However we would like to remind you that Trust costs should be considered and costed at the earliest stage in the development of any future proposals.

May I wish you every success with your research.

Yours sincerely



  
Medical Director and R&D Lead

cc : Sponsor, University of Lancaster

Enc: Approval Conditions Leaflet  
Induction & ID Badge Information, TrustTECH Leaflet





## Appendix 4-D

## Participant Information Sheet

**Study Title: Staff's experience of working with clients with complex or challenging interpersonal difficulties: compassion fatigue and the psychological processes underpinning it**

My name is Rachel Watts and I am a Trainee Clinical Psychologist. I would like to invite you to take part in some research but before you decide it is important you have an understanding about the study. This information sheet tells you about why the study is being done and what it will involve; please take some time to read this. If you decide you may be interested we can talk more about the project by phone or email and I can answer any questions you might have. Some people also find it helpful to discuss it with other people, so please feel free to do this if it would be helpful for you.

**What is the study about?**

The study aims to understand health professionals' experiences of compassion fatigue and the processes underpinning this. Compassion fatigue is when it becomes harder to show empathy. Sometimes people also feel anxious, preoccupied and irritable at these times. Compassion fatigue is a common and an understandable response to the pressures on staff within mental health services and many people experience it at some point in their careers. I would like to find out more about this experience and try to understand a bit more about why this might happen and how people manage it. I am conducting this research as part of the Doctorate in Clinical Psychology programme at Lancaster University.

**Who will be taking part?**

I am hoping to interview 10-15 people. Participants will all be health professionals (e.g. nurses, social workers, occupational therapists, care co-ordinators, senior practitioners) working within a community based mental health team or personality disorder service who have or have had contact with one or more clients who have complex or challenging interpersonal difficulties, who may or may not have been diagnosed as having borderline personality disorder. It is anticipated all participants will have had experience of compassion fatigue to some extent, as most of us experience this at some point in our professional life.

**Why have I been approached?**

I am inviting you to take part in the study because you work within a community mental health team or personality disorder service. At this point I don't know anything about your experiences and whether you work with people with borderline personality disorder or have experienced compassion fatigue. If you decide you

might want to take part then we could have a discussion about whether you are eligible.

**Do I have to take part?**

No, it is up to you whether or not you take part in the project. If you decide you would like to be

involved you will be asked to sign a consent form. If before we meet or during the interview you decide you no longer wish to be involved, you can withdraw from the study without giving a reason. Once the interview has taken place you can still withdraw your data (i.e. the audio recording of the interview or transcript, if this has been completed, the consent form and any contact details you have given me). However, once your interview has been anonymised and analysed it might not be possible for your data to be withdrawn, although every attempt will be made to extract your data, up to the point of publication.

**What will I be asked to do if I take part?**

If you decide to take part in the study we will meet (either where you work, at a local health centre or at your home) to talk about your experience. The interview should last about 45 minutes to 1 hour, but you can stop at any point or we can meet over 2 sessions if you prefer. With your consent, the interviews will be audio recorded to help me remember everything we talk about. I may re-contact you after the interview to follow up on what we discussed but this would be with your consent.

**Will my data be confidential?**

If you agree to take part in the study, any information you provide will be kept strictly confidential. The only exception to this is if I was concerned about your safety or the safety of someone else. If this was the case I will have to break confidentiality and to speak to the relevant person. I will always try and discuss this with you first.

The data collected for this study will be stored securely and only the research team (the researcher and her supervisors) will have access to this data. My field supervisor (Dr XXXXX, Clinical Psychologist) will not have access to the anonymised transcripts but will be involved in the later stages of the analysis and write up. Audio recordings will be destroyed once the study has been submitted and assessed in part completion for the doctorate in clinical psychology. The transcript will be made within 3 months of the interview itself. Your name and other identifiable information will be removed from this transcript. During the study this anonymised transcript will be kept securely and both myself and my academic supervisor will have access to it. Anonymised quotations from your transcript may be used in reports or publications from the study. On completion of the project this anonymised transcript, along with the consent form, will be stored securely at Lancaster University for 5 years from publication, up to a maximum of 10 years, and then destroyed.

Any contact information you give me (either via email or phone) will be kept securely for up to 12 months so that I can write to you and provide a summary of the results, if you wish to receive this. If this information is in email format this will be stored in a separate inbox on a password protected email account. On completion of data collection this information will be transferred to a contact details sheet. If contact information is initially collected via telephone conversations it will be recorded on a contact details sheet and stored electronically on Lancaster University's server. On completion of data collection all contact information will be stored securely at Lancaster University. Consent forms will also be stored securely at Lancaster University.

**What will happen to the results?**

The results will be summarised and reported in part completion of the Doctorate in Clinical Psychology. The results may also be submitted for publication in an academic journal and a participant newsletter will be made available to you detailing the results.

**Are there any risks?**

I don't anticipate there being any disadvantages of taking part but there is a chance that sharing your experiences may lead to some distress. I will check if you have any concerns. If following our interview you experience any distress I would advise you to follow the recommended action on the debrief sheet I provide you with after meeting. This may involve you speaking with your line manager, occupational health or your GP.

**Are there any benefits to taking part?**

Although I hope you find taking part in this study interesting there are no direct benefits from participating. However, I hope that by hearing and understanding your experience it may help to further our understanding of the pressures faced by staff and may also have implications for future staff support groups aimed at improving well being.

**Who has reviewed the project?**

This study has been reviewed and approved by the Faculty of Health and Medicine Ethics Committee and Lancaster University Ethics Committee and by XXXXXX NHS Foundation Trust Research and Development department.

**Where can I obtain further information about the study if I need it?**

If you would like any further information, have any questions about the study or would like to take part please contact me. My details are as follows:

Rachel Watts

Division of Clinical Psychology  
Furness Building  
Lancaster University  
Lancaster  
LA1 4YG

Tel: 07908613784  
Email: r.watts@lancaster.ac.uk

### **Complaints**

If you wish to make a complaint or raise concerns about any aspect of this study and do not wish to speak to the researcher, you can contact:

Dr Craig Murray  
Acting Research Director  
Division of Clinical Psychology  
Bowland Tower East  
Lancaster University  
LA1 4YG

Tel: 01524 592730  
Email: c.murray@lancaster.ac.uk

If you wish to talk to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Professor Paul Bates  
Associate Dean for Research  
Faculty of Health and Medicine  
Lancaster University  
Lancaster  
LA1 4YD

Tel: 01254 593718  
Email: p.bates@lancaster.ac.uk

If you would like more information about research in general please contact Sandra Igbodo who is the research and governance officer for XXXX NHS Foundation Trust on XXXXX or email: XXXXXX

**Thank you for taking the time to read this information sheet.**

## Appendix 4-E

## Consent Form

**Title of Project: Staff's experience of working with clients with complex or challenging interpersonal difficulties: compassion fatigue and the psychological processes underpinning it.**

**Please initial box**

1. I confirm that I have read and understood the information sheet dated 20/05/2013 (version 2).
2. I confirm I have had enough time to consider the information provided, had chance to ask questions and have them answered.
3. I give consent for my interview to be audio-recorded and understand this will be made into an anonymised written transcript. I understand this audio recording will be destroyed following submission of this doctoral thesis.
4. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
5. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication.
6. I give consent for the researcher to use information and anonymised quotations from my interview in any publications, reports, conferences or training.
7. I understand that anything I say will remain strictly confidential and anonymous unless the researcher is concerned for my safety or the safety of someone else. In this situation I understand the researcher will have to share this information.
8. I give consent for my anonymised transcript and this consent form to be kept by Lancaster University for 5 years after the study has finished or following publication.
9. I agree to take part in the study.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

Appendix 4-F

Demographic Information Sheet

<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Age</b>		
<b>Professional Background</b>	<input type="checkbox"/> Social Work <input type="checkbox"/> Mental Health Nursing <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Other .....	
<b>Length of Time Since Qualification</b>		
<b>Length of Time Working With This Client Group</b>		
<b>Ethnicity</b>	<p style="text-align: center;"><b>Asian/Asian British</b></p> <input type="checkbox"/> Bangladeshi  <input type="checkbox"/> Indian  <input type="checkbox"/> Pakistani  <input type="checkbox"/> Any other Asian background  <p style="text-align: center;"><b>Mixed</b></p> <input type="checkbox"/> White & Asian  <input type="checkbox"/> White and Black African  <input type="checkbox"/> White and Black Caribbean  <input type="checkbox"/> Any other mixed background  <p style="text-align: center;"><b>Other</b></p> <input type="checkbox"/> Chinese  <input type="checkbox"/> Any other ethnic group	<p style="text-align: center;"><b>Black/Black British</b></p> <input type="checkbox"/> African <input type="checkbox"/> Caribbean <input type="checkbox"/> Any other Black background  <p style="text-align: center;"><b>White</b></p> <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other White background  <p><b>Other please specify</b></p> <p>.....</p> <p>.....</p>

## Appendix 4-G

### Interview Schedule

#### **Introduction**

Thank you for meeting with me today and for agreeing to take part in this project. As you may remember from the information sheet/our telephone conversation my name is Rachel and I am a Trainee Clinical Psychologist. I would like to ask you a few questions about your experience of working with people with complex or challenging interpersonal difficulties. By this I mean those who may typically be given a diagnosis of Borderline Personality Disorder (BPD), or who you may consider 'risky'. Before we start do you have any more questions about the project? (Researcher to ensure the participant is fully aware of the project and answer any questions).

The interview should take roughly an hour. Please just let me know if you want to pause the interview at any point and have a break. If there are any questions you do not want to answer please let me know and we will move on. Everything we talk about today will remain confidential. However, I may need to share some information if I am concerned about your safety or the safety of someone else, but would discuss this with you first as much as possible.

We now need to go through this consent form. (Researcher to go through the consent form with the participant and both sign this. Researcher to give a copy to the participant).

#### **Interview Questions**

Given the semi-structured nature of the interview the researcher will ask questions around the following areas. It may be that deviations are made should discussion arise that are relevant to the research questions but that are not predefined in this schedule.

To orientate the participant to the topics the researcher will ask them to bring to mind clients who have interpersonal difficulties or those that they might describe as particularly risky. Participants will be encouraged to focus on this client group when answering the following questions.

- How long have you been working with this client group? What sort of work do you do?
- Do you think there are particular challenges in working with this client group? (e.g., Level of risk? level of pain / trauma client has experienced? How they relate / communicate their pain? Ability to stay in a relationship?) Why is it difficult?

- Can you tell me about a recent situation where you have felt anxious/ preoccupied/ irritated when working with a particular client or situation?
- Do you ever feel as if your empathy or compassion is reduced, or seems to have been switched off? Can you describe this experience?
  - What happened?
  - What were your thoughts and feelings at the time?
  - What was happening before you felt like this?
  - How do you feel looking back (if historical example)
  - Looking back what might have helped you at the time?
- What contributes to you feeling the above?
- How does working with this client group impact on:
  - Your wellbeing
  - Your working life
  - Your life generally
- How does the context you work within impact on your work with this client group (i.e. environmental stressors).
- How do you manage these difficulties? Is this difficult? What is difficult about managing this?

Researcher will then stop the recorder and thank the participant for taking part in the interview. Researcher will give the participant the Debrief Sheet.