Doctoral Thesis

The Cost of Caring: What Contributes to Compassion Fatigue?

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Abstract

A growing body of literature has attempted to understand the personal costs associated with professionally caring for others. This thesis aimed to balance both qualitative and quantitative methods to better understand compassion fatigue within mental health and drug and alcohol professions. A qualitative meta-synthesis was conducted in order to understand the lived experience of compassion fatigue, vicarious/secondary trauma, and burnout. Reviewing eleven papers demonstrated that feeling undervalued and lacking resources contributed to experiencing compassion fatigue, secondary trauma, and/or burnout; finding meaning, personal and professional growth, feeling supported, and proactively participating in self-care maintained compassion.

The second aim of this thesis was to better understand compassion fatigue in professionals working in substance misuse services. An e-survey using established quantitative measures investigated the influence of individuals' emotional skills on their responses to workplace and service user specific stressors, and compassion satisfaction and fatigue. A high prevalence of compassion fatigue was found in substance misuse services (57%), yet many more participants also experienced compassion satisfaction (81%). Compassion fatigue was predicted by professionals' perception of the strain which working with substance use had on them, and this relationship was moderated by emotional suppression and emotion contagion ($\Delta R2 = .052$, $F(1, 80)= 5.62$, p.005). The effects of workplace strain on compassion satisfaction was mediated by the meaning that professionals ascribe to their roles (b = 1.20, 95% BCa CI 2.01, -55). This thesis highlighted that professionals' experiences of distress are linked to the context in which they work, and with their relationships with service users, their peers, and the wider organisational culture. Whilst awareness and support at an individual level are necessary to

maintain compassion, it is important that compassion is also addressed at an organisational and cultural level.

Declaration

This thesis presents work done in partial completion of a Doctorate in Clinical Psychology at Lancaster University. The work presented is my original work and has not been presented for any other academic or professional award.

Name: Ellysia-Grace Thompson

Signature:

Date:

Acknowledgement

Firstly, I would like to thank those who took the time to take part in this research. Specifically, I would like to thank the organisations, whom cannot be named to ensure the confidentiality of participants, who supported the project by distributing the study to their teams and contacts, and offering their thoughtful reflections and feedback. I would also like to thank my research and field supervisors, family, and friends for their continued support and encouragement (and spell checking) throughout this process.

Word Count

Section	Main body	References, tables and appendices	Total
Thesis Abstract	286	-	
Systematic Literature Review	8,156	5,264	
Research Paper	8,680	4,793	
Critical Appraisal	3,718	711	
Ethics	4708	3,990	
Total	25548	14,758	40306

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Chapter 1 Literature review

The cost of caring: A meta-synthesis of Mental Health Professionals' experiences of

Compassion Fatigue, Secondary trauma, and Burnout

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Abstract: 246

Main body of text: 7,910

Abstract

Research has identified that there is a personal cost to professionals working therapeutically with others, and a number of descriptive terms have emerged in the literature, including compassion fatigue, secondary trauma, and burnout. This meta-synthesis sought to understand the lived experience of how working with distress and suffering affects mental health professionals by reviewing the current qualitative research. From eleven qualitative papers, three broad themes emerged: understanding the experiences; causes and contributions; and surviving and thriving. Each theme contained three sub-themes. Reflecting the existing literature, when professionals described their experiences, and researchers made sense of these, the concepts of compassion fatigue, secondary trauma, and burnout frequently overlapped, and further research is needed to understand the similarities and differences. The results demonstrated that mental health professionals were aware of the impacts of their roles and factors which maintained their capacity for compassion. Whilst exposure to distress was a factor in developing compassion fatigue, secondary trauma, and burnout, many participants identified that being undervalued and lacking the physical and emotional resources to do their jobs were contributing factors. Finding meaning; experiencing professional and personal growth; feeling supported; and being able to identify and manage their own physical, social, and psychological needs helped participants to maintain their wellbeing. Yet, despite having these understandings, mental health professionals were not always able to maintain their well-being proactively, suggesting that interventions need to focus on wider social and organisational attitudes towards self-care.

Keywords: *Compassion Fatigue, Secondary trauma, Burnout, Mental Health, Qualitative*

LITERATURE REVIEW

Empathy, the ability to understand others, and compassion, the awareness of others' suffering and the desire to lessen it (Oxford Dictionary, n.d), are common and necessary skills for those working therapeutically (Thompson, Amatea & Thompson, 2014). However, trying to understand others in distress can be psychologically costly for mental health professionals (MHP) (Thompson et al., 2014). The literature on the negative impact of caring for others contains three related, and often overlapping concepts compassion fatigue (CF), secondary trauma (ST, a term frequently used interchangeably with vicarious trauma), and burnout. The overlap in these terms has resulted in a lack of conceptual clarity (Craig & Sprang, 2010). In a paper reviewing the concept of CF it was found that the lack of clarity had led to the concept not being generalizable across professions (Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski, & Smith-MacDonald, 2017).

Burnout describes the experience of physical and emotional exhaustion related to increased levels of work stress (Pines & Aronson, 1988), and has three factors, including emotional fatigue, depersonalisation, and feeling a lack of accomplishment (Hill, Vaccarino, & Daly, 2015). CF and burnout have been used interchangeably, and the similarities and differences between burnout and CF are not always easily established (Hill et al., 2015). However, Figley (2002) differentiates CF from burnout as an experience that is unique to professions that care for others. For Figley (2002), CF is the exposure to distress and suffering, rather than a more general state of exhaustion from workplace demand. Therefore, burnout may be defined as a reaction to work place stress, whereas CF could be considered a product of an empathic relationship (Hill et al., 2015). However, there are contradictions in the literature, with empathy being associated with burnout in a number of research studies (Raab, 20014; Tei et al., 2014; Wagaman, Geiger, Shockley, & Segal, 2015).

There is also a lack of clarity regarding ST, a descriptive term for when an individual experiences long-term negative changes in how they perceive the world as a reaction to being exposed to others' traumatic experiences (Stebnicki, 2007). An important feature of ST is that professionals take on others' emotional distress, impacting on their own cognitive schemas, memories, and sense of self (Hernández, Engstrom, & Gangsei, 2010). Figley (2002) suggests that CF is a broader term for ST and describes the cost of working with others in distress, rather than exposure to their trauma stories. However, overlapping with ST, research has identified that CF often includes changes in perceptions (Turgoose & Maddox, 2017).

Stamm (2012) organises these concepts in the model of professionals' quality of life (Figure I), whereby CF is a precursor to the longer-term psychological experiences of burnout and trauma (Stamm 2012). Within this model, Stamm (2012) describes CF in the context of the opposing term Compassion Satisfaction, whereby individuals feel valued in their role and have positive experiences about their contribution. For Stamm (2012), an important component of CF is the experience of not making a difference. The model also suggests that if CF is left unaddressed it can lead to ST and burnout (Stamm, 2012).

Insert Figure I

In order to make sense of the differential definitions of CF, ST, and burnout, some of the literature has explained experiences of professional exhaustion using two alternative hypotheses (Tei et al., 2014). 'Compassion fatigue theory' describes exhaustion as associated with caring for others experiencing significant distress and thus, the more empathic the professional is, the greater risk of developing CF (Tei et al., 2014). Alternatively, the 'emotional dissonance theory' outlines how the conflict between an individual's experienced emotions and the emotions they

express in order to conform to rules, social expectations, and occupational requirements results in emotional dysregulation (Bakker & Heuven, 2006). These two explanations may relate to the differences in experiences between CF, ST and burnout.

Despite the differing theories and terminology of the three concepts, within the literature each has been associated with the concept of empathy. The literature on empathy frequently divides the concept into two components: cognitive empathy, the ability to take someone's perspective, and affective empathy, whereby an individual shares a similar emotional response to others' experiences (Smith, 2006). If empathy is the common factor between CF, ST and burnout, it could be argued that cognitive empathy may lead to a different form of exhaustion and manifest as different forms of distress than affective empathy. For example, a professional empathising emotionally may experience more emotional consequences than an individual empathising cognitively.

The Current Literature

Research has consistently established the prevalence of CF (Ray, Wong, Write, 2013; Turgoose & Maddox, 2017), ST (Bercier & Maynard, 2015), and burnout (Thompson & Thompson, 2014) in MHP. A large body of research exists on the correlations and contributing factors to CF, ST, and burnout in health professionals. Demographic variables are highlighted, such as age and gender, with females being more likely to experience CF (Sprang, Clark & Witt-Woosley, 2007) and burnout (Garrosa, Moreno-Jimenez, Liang, & Gonzalez, 2008). Job related factors such as fewer years of experience and specialist training and higher level of patient contact and responsibility (Sprang et al., 2007; Craig & Sprang, 2010) increase CF and burnout (Lim et al., 2010). Professional exhaustion is also influenced by personal factors such as emotional awareness (Thomas, 2013; Guiterrez & Mullen, 2016), levels of empathy (MacRitchie

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& Leibowitz, 2010), and self-care practices (Gutierrez, & Mullen, 2016; Thompson et al., 2014).

Professionals' personal experiences and experiences of trauma also influence CF (MacRitchie &

Leibowitz, 2010) and ST (Tei, 2014). Furthermore, how well the role fits with the individual's

values and personal beliefs influences experiences of CF and burnout (Ray et al., 2013). As well

as understanding what contributes to CF, research has highlighted the impact that these

experiences have at an organisational level. CF, ST, and burnout can affect the quality of care

provided, as professionals lose their ability to respond empathetically and objectively (Lawson,

2007). Furthermore, these experiences also contribute to a high staff turnover in mental health

services, which may reduce the cohesiveness and functioning of teams (Conrad & Kellar-

Guenther, 2006).

A number of reviews have been completed on CF, ST, or burnout. For example, Hill et

al., (2015) reviewed the construct of CF using both quantitative and qualitative literature to

explore the definition. Quantitative reviews have also focused on specialist professions, for

example nursing (Yang & Kim, 2012), health professionals (van Mol, Kompanje, Benoit,

Bakker, & Nijkamp, 2015), burnout interventions for healthcare professionals (Cocker, & Joss,

2016), and cancer specialists (Najjar, Davis, Beck-Coon, & Doebbeling, 2009). Turgoose and

Maddox (2017) recently completed a relevant quantitative review of the contributing factors to

CF in MHP. This included 32 quantitative studies on CF, which found that previous experiences

of trauma, high levels of empathy, increased caseload, and less clinical experience were

associated with increased CF (Turgoose & Maddox, 2017). Conversely, mindfulness, self-care,

and compassion satisfaction reduced CF (Turgoose & Maddox, 2017). Sinclair et al. (2017)

recently completed a large narrative review to critically analyse and clarify the concept of CF

across the health care professions. The review included 90 studies; of these, three studies were

qualitative, and included papers that researched CF across all health care professions, related

interventions, and discussion papers. CF was found to be a common phenomenon amongst health

care professionals, and the authors concluded that due to the diversity of responsibilities and the

complexity of individual stress responses, there were multiple and conflicting definitions and

theories on CF within the literature reviewed (Sinclair et al., 2017). These are poorly understood

and need to be re-conceptualised (Sinclair et al., 2017).

Quantitative research has been valuable in establishing relationships that may indicate the

relationship between CF, ST, and burnout, and in trying to develop definitions from which the

constructs can be compared (McEvoy & Richards, 2006). However, this body of research does

not capture the lived experience of MHP who have had CF, ST, and burnout. Much of the

literature does not address the meaning and impacts of these experiences for the individual and

the wider mental health profession beyond describing the outcomes related to CF. Qualitative

methods offer an opportunity for unexpected themes to emerge that may be missed in research

with pre-determined standardised approaches (McEvoy & Richards, 2006). Given that CF, ST,

and burnout are emotional experiences linked to an individual's professional role, qualitative

research may offer new understandings of these experiences, the impacts, and how people

manage them. In comparison to quantitative reviews, which typically seek to quantify a cause

and effect, a qualitative synthesis attempts to understand and re-interpret lived experiences

(Walsh & Downe, 2005). One qualitative review was identified: Marsey (2013) reflects on the

existing literature with the authors own narrative around CF. Rather than systematically

reviewing the literature, the author takes a reflective narrative approach, contextualising her own

experiences of CF in existing theory using quotes from the literature up to 2010.

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The Aim of the Current Review

       To the author's knowledge, there are no existing systematic reviews of qualitative research that capture the lived experiences of CF, ST and burnout in professionals working exclusively in mental health settings. A scoping search revealed a set of qualitative papers that focused on experiences of CF, burnout, and ST within the mental health profession. The author noted that these papers covered a range of specialists within mental health services, including trauma, child welfare, and sexual abuse as well as general MHP. This review sought to understand the commonalities, and differences, between these papers to develop an in-depth understanding of how CF, ST, and burnout affect the mental health profession. As such, the research question was developed: What are MHP lived experiences of CF, ST, and burnout?

Method

Design

       Meta-ethnography is an inductive and interpretive approach developed by Noblit and Hare (1983), which seeks to review qualitative research systematically. The approach examines how qualitative studies relate to, and differ from, each other through a process of construct comparison in order to create an understanding beyond that of the original research (Toye et al., 2014). By identifying interpretive metaphors and the reciprocal translation of these metaphors, the reviewer aims to maintain the meaning of the original text and relationships between concepts, which serves to preserve integrity of the participants' experiences (Britten et al., 2002). To do this the reviewer interprets and integrates three levels of information: first order constructs are the participants' direct understandings which are captured by direct quotes; second order constructs are researchers interpretation and conclusion; and third order interpretations are the synthesis of the first and second order constructs into a new understanding (Schutz, Natanson, &

van Breda, 1963). Meta-ethnography can produce three outcomes of synthesis including translating the papers with similar results into one another to create a stronger argument, refuting results and conclusions which do not agree, or creating a new line of argument (Atkins, et al, 2008). Noblit and Hare's (1988) seven-step guide to meta-ethnography (Table I) was followed.

Insert Table I

Developing the Research Question and Search Strategy

This review was informed by the ENTREQ guidance (Tong, Flemming, McInnes, Oliver & Craig, 2012) which provides guidance for reporting explicit and comprehensive qualitative reviews, offering 21 statements organised in the domains of: introduction, methods and methodology, literature search and selection, appraisal, and synthesis of findings (Tong et al., 2012). To formulate research questions and the search terms, the SPIDER tool (Cooke, Smith & Booth, 2012) was used (Table II). This tool was designed specifically for qualitative research and encourages reviewers to consider the sample, phenomena of interest, design, evaluation and research methods (Cooke et al., 2012). The tool also suggested that search strategies make use of Boolean operators to yield the greatest results and offer the combination outlined in table II (Cooke et al., 2012).

Insert Table II

To formulate search terms, a brief overview of the literature identified key words used to describe CF, ST and burnout. The PsychInfo database thesaurus was used to generate further search terms for MHP, qualitative methodology, and 'experiences', and these were used with Boolean operators (Table II). Five databases were searched separately (Figure II). The method of citation pearl searching was also used, where the references of key texts were hand searched.

Exclusion and Inclusion Criteria

Papers were included if they were qualitative peer reviewed published journal articles on the experiences of CF, burnout, and ST in professionals working therapeutically in mental health services. Papers were excluded if they were discussion or reflective papers, did not sample the target population, were solely quantitative, or focused on a specific and isolated trauma event, such as a natural disaster. Papers that primarily focused on shared trauma, where the professional had experienced the same trauma as their service user (Jenkins & Baird, 2002) were deemed as conceptually different for CF, ST, and burnout, and were therefore excluded. Papers that reviewed specific interventions or service related projects for CF, ST, or burnout were also excluded on the basis that they were not generalizable to the mental health profession. Figure II outlines the search results and process of refining the results. A total of 1065 papers were retrieved from the literature search, of which 620 titles and abstracts were reviewed. From this, 82 papers were read in full, revealing 11 relevant papers.

Insert Figure II

Appraisal of Selected Papers

In order to synthesise the papers identified, a method for appraising the qualitative studies was beneficial. However, in the literature, the definition of good qualitative research is disputed and there is disagreement if, or how, qualitative research should be appraised (Leung, 2015). Judging the quality of qualitative research is complicated by the varying methodologies and epistemologies employed; the interpretative qualities that make qualitative research unique are also hard to measure (Dixon-Woods, Shaw, Agarwal, & Smith, 2004). For example, interviews and focus groups have different methodologies, which give rise to different flaws that require

appraising in different ways. Furthermore, it is important to be aware of the context in which the qualitative research was undertaken and what the limitations of these contexts might be (Dixon-Woods et al., 2004).

Within the literature, debates have arisen about the value of assessing qualitative research based on methodology (Dixon-Woods et al., 2004) or the interpretation of the results (Lincoln et al., 2011). Given the variations in definition and interchangeable use of the concepts of CF, ST, and burnout, a method of appraisal which allowed the reviewer to reflect on the justification for the study, interpretations of the results, and the way in which they link this to the existing literature was important. It was also important to consider the various professions (with different research backgrounds) which have contributed to the literature on CF. The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong, Sainsbury & Jonathan, 2007) was used. This 32-item tool was designed to provide a comprehensive list of criteria which should be included when reporting qualitative research, and benefits from focusing on comprehensiveness of the reporting rather than methodology (Tong et al., 2007). To do this, the checklist uses three domains: research terms and reflexivity, design, analysis, and findings (Appendix A).

Process of Synthesising the Data

The first step of analysis involved reading and re-reading each paper, and making notes of key themes, phrases and metaphors. The reviewer then assessed the similarities and differences across the papers. Following this, first order (original quotes) and second order (researchers' analysis) constructs across the papers were reviewed and combined to create third order interpretations and new understandings of mental health professionals' experiences of CF, secondary trauma and burnout. Finally, these were reviewed and developed into themes. To

maintain the integrity of participants' experiences, the themes are illustrated by first-order

constructs. Table IV demonstrated the process of analysis.

Results

Study Features and Quality

Eleven studies were identified as relevant. The methodological characteristics of these

studies are outlined in Table III, and Appendix A shows the COREQ reporting quality ratings.

All of the papers discussed experiences of working therapeutically in mental health settings

using the concept of either CF, ST or burnout. Several papers used both or all terms. Two of the

included papers utilised a mixed-methods design and were included as the qualitative

components could easily be extracted (Hanson, 2015; Killian, 2008). Of the eleven papers, three

focused primarily on what helped professionals to manage CF (De Langee & Chigeza 2015;

Ling, Hunter & Maple 2014; Lin, 2012). Two papers included other professionals, such as school

staff who had direct contact with service users, and were included as the majority of the sample

did work therapeutically (Hanson, 2015; Hummelvoll & Severinsson, 2001).

The papers were international in origin (Table III), which provided a diverse range of

ethnicities and cultural settings. There was a range of specialist mental health disciplines and

therapeutic settings represented, including specialist trauma (Hummelvoll & Severinsson 2001;

Ling et al., 2014; Satkunanayagam, Tunariu & Tribe 2010; Sui & Padamanabhanunni, 2016),

sexual abuse therapists (De Langee & Chigeza, 2015), and residential/inpatient mental health

(Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015; Killian, 2008), as well as general MHP

(Hanson, 2015; Lin, 2012; Ohrt & Cunningham 2012; Sim, Zanaedelli, Loughran, Mannarino &

Hill, 2016). The papers also represented professionals at different stages in their profession, with

one paper comparing early and late stages of career (Sim et al., 2016).

Insert Table III

Qualitative methods were considered appropriate for all of the research questions and aims of the selected studies. The papers reported between 12 and 23 criteria out of 32 in the COREQ (Appendix A). Areas that were most lacking were descriptions of the research team and their interaction with the participants and data, sampling methods, and participant feedback. However, all of the papers included participant quotations and the core themes derived from these were considered consistent.

Synthesis

Researchers and participants understood and described CF, ST, and burnout in three different ways: the ways in which it affected them, the causes, and ideas and experiences of what factors mitigate or prevent. These ways of understanding CF, ST, and burnout were influenced by the context in which the research was carried out, including the research question, aims, and whether the participants had experienced work stress and/or "recovered". This informed three overarching themes: understanding the experiences; causes and contributions; surviving and thriving. Each theme contained three subordinate themes. Table IV illustrates the synthesis process, including how constructs and ideas have been translated into each other to create superordinate themes and new interpretations.

Insert Table IV

Understanding the experiences. This theme captures participants' first-hand experiences of CF, ST, and burnout, the impact this has had on their professional and personal lives, and the researchers' interpretations based on these reports. Incorporated in this theme are three sub-themes: feeling disempowered, seeing the world negatively, and shutting down.

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Feeling disempowered. When experiencing CF, ST, and burnout, professionals felt

hopeless and disempowered in their roles (Satkunanayagam et al., 2010; Sim et al., 2016; Sui &

Padamanabhanunni, 2016), and the lack of empowerment and change impacted negatively on

MHP. Five papers (Hernandez-Wolfe et al. 2010; Killian, 2008; Satkunanayagam et al., 2010;

Sim et al., 2016; Sui & Padamanabhanunni, 2016) observed that hearing stories of distress and

hardship affected MHP negatively and resulted in emotional disturbances such as anger and

anxiety. Participants described the shock and sadness of the stories that they heard (Lin, 2012),

and how this rendered them feeling frustrated and powerless (Hernandez-Wolfe et al., 2010).

One participant captured this experience:

> I feel a helpless rage…the anger that comes from the fact that you know you tried your
>
> best to help…you can only do so much (Sui & Padamanabhanunni, 2016, p. 130).

Seeing the world negatively. Being exposed to these experiences altered MHP

perspective of their sense of self, others, and the world both professionally and personally.

Participants described how difficulties at work affected them in their personal lives and

relationships (Killian, 2008; Ohrt & Cunningham 2012; Satkunanayagam et al., 2010; Sui &

Padamanabhanunni, 2016). One participant described:

> I definitely carry feelings home from work and then have to figure out a way to deal with
>
> those interpersonally (Killian, 2008, p. 35).

One participant felt that they had developed "a tainted view of the world" (Sui &

Padamanabhanunni, 2016, p. 129). These altered perspectives had negative impacts on MHP

feelings of safety for themselves and their families (Sim et al., 2016), and affected their personal

and sexual relationships (Killian, 2008). This led MHP to feel exhausted, and one participant

described "having nothing left to give" (Killian, 2008 p.35). Sui & Padamanabhanunni (2016)

suggested that these experiences are caused by changes in MHP 'global cognitive schemas' due to continual exposure to others' negative experiences and suffering.

Countering this, some MHP described how they experienced their job as "humbling" (De Langee & Chigeza, 2015, p.58), and how this helped them to put their own lives into perspective and focus on the positives:

It really causes me to understand that I don't have nearly as severe circumstances in my own life, and to have more confidence (Hernandez-Wolfe et al., 2010, p.162).

To do this, some MHP made upward or downward comparisons with wider societal and cultural issues to contextualize what they heard from clients (Hernandez-Wolfe et al., 2010). One participant concluded:

…pain is pain and it's existential…This work has broadened that and deepened that philosophy (Hernandez-Wolfe et al., 2010, p.163).

Authors suggested that taking this stance might support MHP to be less affected by the work they do, relate more effectively to clients, and tolerate frustration (Hernandez-Wolfe et al., 2010). The contradiction within the literature may relate to whether MHP had experienced CF or not, and whether they were reflecting on these experiences retrospectively. Alternatively, these different viewpoints could highlight the influence of interpersonal thinking styles such as optimism and hope.

Shutting down. Some participants described becoming emotionally disconnected from clients and the emotional content of their work (Hanson, 2015; Hernandez-Wolfe et al., 2010; Hummelvoll & Severinsson 2001; Killian, 2008; Sui & Padamanabhanunni, 2016). For some, this was linked to an over exposure or repetition which had a numbing effect (Hanson, 2015). For others, shutting down related to having "a hard time listening to horror stories" (Hernandez-

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Wolfe et al., 2010, p.162) and one author suggested that participants become avoidant of clients (Hanson, 2015). Avoidance may be a coping strategy that limits the impact of emotional content by distancing MHP from the client (Hanson, 2015).

Causes and contributions. It was common for MHP and researchers to discuss CF, ST, and burnout in terms of things that contribute to or made it worse. Understanding the factors that surround CF, ST, and burnout was a way of understanding the experiences themselves. Three significant areas emerged, including difficult relationships with others, the demands of the role, and poor self-awareness.

Difficult relationships with others. Participants did not feel that others valued and supported the work that they did (Hanson, 2015; Hummelvoll & Severinsson 2001; Killian 2008; Lin 2012; Ohrt & Cunningham 2012; Satkunanayagam et al., 2010; Sim et al., 2016; Sui & Padamanabhanunni, 2016). The lack of value placed on MHP could be shown both in personal interactions with peers, and organisationally in the lack of investments in training, self-care, and resources. Having negative work environments (Sim et al., 2016) and being criticised or having their abilities questioned by others (Lin, 2012) increased CF. This had a significant impact on MHP perception of their ability to cope and help (Lin 2012, Sim et al., 2016).

Participants identified that their superiors could be a source of support. However, superiors often "lost sight" (Hanson, 2015, p.51) of what was important, valuing the quantity of work over quality (Hanson, 2015; Killian, 2008; Lin 2012; Ohrt & Cunningham 2012; Sim et al., 2016). There was a disconnection between MHP working directly with clients and management. This highlighted the importance of management understanding the intricacies of therapeutic work (Hanson, 2015; Hummelvoll & Severinsson, 2001). Poor relationships with superiors led to conflict, and one participant described "a sense of insecurity and anger" (Sim et al., 2016, p.392).

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Relationships also influenced whether MHP were able to engage in self-care. Superiors did not always acknowledge or prioritise the need for self-care, and this resulted in a difficult work place culture (Ohrt & Cunningham, 2012). One participant described how others assumed that because of the inherent skills of MHP that they are naturally able to care for themselves (Ohrt & Cunningham, 2012). Six papers concluded that peer support and good supervision was important to support teams and the individual in order to maintain their wellbeing (Hanson, 2015; Hernandez-Wolfe et al., 2010; Hummelvoll & Severinsson 2001; Ling et al., 2014; Sim et al., 2016; Sui & Padamanabhanunni, 2016). One MHP reflected:

Ideally, you have to sit-down with a person and do supervision. So they have a chance to talk about how they're feeling, the problems they are having, in a safe place... (Ohrt & Cunningham, 2012, p. 94).

The demands of the role. Linked to the theme of professional relationships, MHP found that higher expectations, demands, greater complexity of cases, and range of duties increased levels of stress (Hernandez-Wolfe et al., 2010; Hummelvoll & Severinsson, 2001; Killian, 2008; Lin 2012; Ohrt & Cunningham, 2012; Sim et al., 2016). These higher expectations often appeared to be the result of the poor supervisory and management relationships mentioned above, and linked with lack of understanding of the therapeutic role. MHP were expected to produce results quickly:

…it was a lot of treat and street…they come in, and you're basically working on discharge paperwork… (Ohrt & Cunningham, 2012, p. 95).

One participant reflected on how this increased pressure and detracted from the therapeutic role:

> …now you have to put in the time and you have to make the numbers and you lose time
>
> to create relationships or talk about what you are doing. (Ohrt & Cunningham, 2012, p.
>
> 94).

When professionals were unable to support their clients, this appeared to reduce satisfaction and increase feelings of self-doubt: "…Am I helping…Does this matter?" (Ohrt & Cunningham, 2012, p. 95).

Multiple roles and duties, particularly administrative duties, took time away from MHPs' therapeutic work (Hernandez-Wolfe et al., 2010; Ohrt & Cunningham, 2012; Sim et al., 2016). These duties increased levels of frustration when they were experienced as unnecessary or preventing MHP from working effectively. One participant summarised:

> …it took away from the services I was able to offer. But most of all it took away from
>
> me. You know, my energy levels… (Ohrt & Cunningham, 2012, p. 94).

Poor self-awareness. Being unable to notice the early signs was identified as a risk factor (Hanson, 2015; Killian, 2008; De Langee & Chigeza 2015; Ling et al., 2014; Lin 2012; Ohrt & Cunningham, 2012; Satkunanayagam et al., 2010; Sim et al., 2016). Participants were aware of the physical and emotional experiences of exhaustion, including changes in emotion, thinking, and somatic symptoms (Ling et al., 2014; Sui & Padamanabhanunni, 2016). However, collectively the papers suggested that despite this knowledge, MHP were less able to notice and act upon the early signs of CF, ST, and burnout. Many participants retrospectively learned where their emotional boundaries were (Ling et al., 2014; Lin, 2012; Ohrt & Cunningham, 2012; Sim, et al., 2016; Sui & Padamanabhanunni, 2016). Lin (2012) suggested that MHP go through stages of awareness including self-awareness, self-assessment, and self-care in order to manage CF.

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Surviving and thriving. All of the papers offered some insight into how participants have recovered or avoided CF, ST, and burnout. Of the many suggestions, three consistently emerged and generated the subthemes: finding meaning, success, and growth; drawing strength from others; and actively taking care.

Finding meaning, success, and growth. Experiencing success and growth helped MHP to keep in touch with the meaning and purpose in their work and maintain compassion (Killian, 2008; De Langee & Chigeza, 2015; Ling et al., 2014; Ohrt & Cunningham 2012; Satkunanayagam et al., 2010; Sim et al., 2016). One participant described:

> … what pushes me towards the resilient end of the spectrum is that this work shapes my
>
> sense of self and my identity as a person who is trying in her own little way to be
>
> working towards a better world (Hernandez-Wolfe et al., 2010, p. 165).

Being able to notice the impact of their roles helped MHP to better recognise change, which provided a source of motivation (Hummelvoll & Severinsson, 2001; Ling et al., 2014; Satkunanayagam et al., 2010). Success could be in the meaning and values they assigned to their role and/or more tangible outcomes, such as gaining clients' trust (Sim et al., 2016), as well as recognition from peers and supervisors (Hernandez-Wolfe et al., 2010; Ling et al., 2014; Ohrt & Cunningham, 2012; Sim et al., 2016; Sui & Padamanabhanunni, 2016). Finding meaning and purpose was an active process that required "hope that change is possible" (Satkunanayagam et al., 2010, p.48). Beyond direct therapy, being able to fulfil a wider social responsibility and participate in empowering others at both individual and community levels was important (Ling et al., 2014; Lin, 2012; Satkunanayagam et al., 2010; Sim et al., 2016). For some, maintaining interest and purpose involved creating new ways of working and networking with others (Sim et al., 2016).

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Participants had experienced personal growth (Satkunanayagam et al., 2010; Sui & Padamanabhanunni, 2016). Some MHP were able to draw personal strength from witnessing others coping with and overcoming distress and adversity, which led to a greater sense of optimism in their personal and professional lives (Sui & Padamanabhanunni, 2016). One participant described:

> Why am I here? What is it about this job that has pulled me here and what is it that I need to learn. (Ohrt & Cunningham, 2012, p. 96).

It was important for MHP to be supported in growth, and this was linked to feeling invested in by supervisors and having opportunities to go on training (Ling et al., 2014; Sim et al., 2016). Having these opportunities promoted autonomy and variety in the work place, and maintained enthusiasm (Ling et al., 2014). In contrast to previous themes, when MHP had opportunities for growth through training and supervision they felt valued by others (Hanson, 2015; Hummelvoll & Severinsson, 2001; Ohrt & Cunningham, 2012; Sim et al., 2016), Sui & Padamanabhanunni, 2016).

In seeing success, growth, and the value in their work, MHP were able to perceive challenge as positive (Hernandez-Wolfe et al., 2010; De Langee & Chigeza, 2015; Ling et al., 2014). For example:

> ….it stretches me, it forces me to think…somehow it fits for me (Ling et al., 2014, p. 306).

In contrast to previous themes, MHP noted that the complexity of cases offered variation and opportunity to develop their skills:

> They're quite complex…There's always opportunity for skills to be developed even further …so the variety is the reason to stay (Ling et al., 2014, p.306).

Seeing challenges as an opportunity appeared to be linked to MHP interpersonal factors such as optimism, and compatibility with their values and the sense that "it's for me, it fits" (Ling et al., 2014, p.303).

   Drawing strength from others. Having space to process work stress was important for maintaining MHP wellbeing (Ohrt & Cunningham, 2012; Satkunanayagam et al., 2010; Sim et al., 2016: Sui & Padamanabhanunni, 2016). It was important that MHP were able to access others with similar experiences in order to feel validated and have opportunities to problem solve (Killian, 2008; Sim et al., 2016). Being able to spend time with colleagues informally, and having a balance "which allows joking and being serious" (Killian, 2008, p.36) was important for maintaining a positive work atmosphere (Hummelvoll & Severinsson 2001; De Langee & Chigeza, 2015; Sim et al., 2016). One author suggested that this related to the social nature of helping professions (Sim et al., 2016).

   Supervisors who prioritise self-care, a culture of self-awareness (Killian, 2008) and positive relationships amongst the team (Sim, et al., 2016), encouraged MHP to be more aware of CF, ST, and burnout. Authors concluded that when professionals had access to supportive peers and supervisors they felt more valued, and this increased their sense of achievement, enthusiasm and team work (Hanson 2015; Hernandez-Wolfe et al., 2010; Hummelvoll & Severinsson, 2001; De Langee & Chigeza, 2015; Ling et al., 2014; Ohrt & Cunningham 2012; Sim et al., 2016; Sui & Padamanabhanunni, 2016). One participant summarised:

> Wellness comes from the agency itself through feeling valued as an employee [when] someone hears you in the company and that you have a voice…. People feel happier, more rewarded, and better. (Ohrt & Cunningham, 2012, p.96).

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Equally, it is important for MHP professionals to socialise with others outside of the profession, who did not have similar experiences, in order to gain perspective (Killian, 2008; Sim et al., 2016). One participant explained:

> Talking to friends….socialising, playing with my daughter those things that relieve stress. (Killian, 2008, p. 36).

Being able to draw strength from the support of friends and family was important but sometimes difficult to do when work affected their relationships (Killian, 2008; Sui & Padamanabhanunni, 2016). This was closely related to being able to maintain a work life balance and being able to prioritise time away from work with loved ones (Killian, 2008; Lin 2012).

Actively taking care. It was important for MHP to look after their own emotional and physical wellness at work, and for MHP to be able to reflect on their own wellbeing (Hummelvoll & Severinsson, 2001; Killian, 2008; De Langee & Chigeza, 2015; Lin 2012, Sim et al., 2016). This included proactively identifying things that they may find challenging, and personal triggers. In a reversal of the themes mentioned above, authors concluded that having good self-awareness might help MHP recognise early signs of CF, ST, and burnout (Sim et al., 2016).

By having self-awareness MHP were able to set limits in their work place (Hanson, 2015; Ling et al., 2014; Sim et al., 2016). This included work related boundaries, such as limiting caseload and level of client complexity (Sim et al., 2016). When MHP were able to control their work schedule, they had an increased sense of autonomy and control (Sim et al., 2016). MHP who maintain their compassion actively separated their own experiences from their clients, allowing them to not be affected by others' distress (Hanson, 2015; Killian, 2008; Satkunanayagam et al., 2010; Sim et al., 2016). In contrast to avoiding clients, emotional

boundaries were characterised by a balance between being able to engage with clients

meaningfully, whilst protecting MHP emotions:

> …knowing how to hear it one step away from it and still be able to empathise… (Ling et
>
> al., 2014, p.304).

Adjusting self-expectations was something that MHP learned with experience (Satkunanayagam

et al., 2010) and allowed MHP to focus on the quality of their work and identify what was

important to them (Lin 2012; Ohrt & Cunningham, 2012; Sim et al., 2016; Sui &

Padamanabhanunni, 2016):

> …in those days it would be more like, okay just tell me how many clients I have
>
> seen…been invited to conferences to speak and feel important but now, more like how
>
> much can I give to another person...(Satkunanayagam et al., 2010, p.48).

> Participants who continued to thrive in their jobs regularly planned or took part in self-

care activities; most commonly this was exercise, being outdoors, and socialising (Hanson, 2015;

Killian, 2008; Ling et al., 2014; Lin, 2012; Ohrt & Cunningham, 2012; Sim et al., 2016).

However, planning self-care activities and then not being able to do them can "have the opposite

effect" (Killian, 2008, p.36). Forced or superficially encouraged self-care was unhelpful and seen

as "tokenistic and superficial" (Ohrt & Cunningham, 2012, p.97). Self-care was about "taking

time for yourself" (Killian, 2008 p.36); this suggests that it is important for self-care activities to

be relevant to the individual's lifestyle.

Discussion

> From eleven papers, three broad themes were developed: understanding the experiences;

causes and contributions; and surviving and thriving. None of the papers identified for this meta-

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synthesis were included in the narrative synthesis completed by Marsey (2013), Turgoose &

Maddox (2017), or Sinclair et al. (2017).

The lack of conceptual clarity has led to theoretical confusion and the interchangeable

use of the terms, making CF, ST, and burnout difficult to research (Sinclair et al., 2017). In

reviewing the qualitative literature, the same pattern emerged. Despite some authors' efforts to

focus on CF, ST, or burnout in their research questions, participants frequently reported

experiences related to each of these concepts. Therefore, the differences in experiences described

by participants may be a result of the lack of conceptual clarity, and further theoretical

development is necessary to clarify the subtleties between CF, ST, and burnout.

Similar to existing descriptions in the literature, MHP experienced CF as impacting on

their ability to maintain levels of compassion and empathy (Figley 1995, 2002; Stamm, 2012).

There was evidence that this included both cognitive empathy, for example blaming, and

affective empathy, where MHP withdrew their emotional availability. These experiences

occurred to such an extent that participants experienced changes in their worldviews, self, and

relationships with others. Therefore, the qualitative literature suggests that MHP may experience

CF in two ways: withdrawing from or feeling overwhelmed by others. Figley (2002) describes a

sequence of factors that culminate in CF, beginning with prolonged exposure to suffering, and

resulting in high empathic concern that requires empathic ability and expenditure of emotional

energy. Therefore, the differences in experiences highlighted in this review may be due to the

stage at which participants were experiencing CF. Despite both experiences being present across

the eleven papers, regardless of the research questions, the variances may demonstrate the need

for differing concepts. Becoming withdrawn may relate more to CF, whilst feeling emotionally

overwhelmed and the permanent disruption of the individual's cognitive schema may be

associated with ST (Stebnicki, 2007). Equally, it is possible that these experiences are on a

continuum and one progresses into another (Stamm, 2012). These different experiences may

relate to different interpersonal coping styles, the importance of which is well established in the

stress literature. Research has identified that coping styles can be broadly divided into avoid or

approach coping (Roth & Cohen, 1986). Therefore, avoid or approach style of coping may

account for why some professionals withdraw whilst others feel overwhelmed.

From the literature reviewed, it became apparent that CF, ST and burnout do not occur

solely because of being exposed to trauma or distress. MHP in this review identified contributing

factors as poor organisation structures and resources, lack of support, and their own ability to

meet their needs. These factors have been identified in the quantitative literature (Turgoose &

Maddox, 2017). However, the qualitative literature suggests that these may be the primary

contributing factors. This finding also resonates with models of compassion, which suggest that

to be compassionate requires individuals to make appraisals of their resources, including goal-

relevance and coping ability (Goetz, Keltner, & Simon-Thomas, 2010). Similarly, the qualitative

literature demonstrated that professionals experiencing CF made negative appraisals of their

resources and their internal coping ability, which manifested as issues with hope, finding

meaning and professional interest. If an individual makes an appraisal that they are physically or

psychologically unable to cope with and thus offer compassion, Goetz et al. (2010) hypothesized

that they are likely to experience distress. Goetz et al. (2010) note the connection between

compassion and anger, suggesting there are evolutionary functions of these negative emotions in

producing co-operation and reciprocity. Therefore, MHP who experience compassion towards an

individual may also experience anger towards the systems or individuals who partake in creating

the negative event or experience that caused distress (Goetz et al., 2010). It is possible that,

whilst participants felt compassion for their clients, they felt anger towards the systems

(including services) that created their distress and that limited their resources.

Reviewing the qualitative literature highlighted the importance of relationships.

Experiencing negative work place relationships with peers and supervisors was related to lack of

understanding, value, and respect for the role, and had a significant influence on the development

of CF, ST, and burnout across the papers. Negative relationships fostered environments that were

demanding of professionals, resulting in MHP feeling overworked and unable to fulfill their roles

successfully. Having positive supervisory and peer relationships helped MHP to better reflect

and process their experiences, and encouraged engagement in self-care activities. Good

relationships were also an important element in participants experiencing successes and growth.

Whilst the importance of support is highlighted in the existing literature (Jenkins & Baird, 2002;

Sprang et al., 2007; Sinclair et al., 2017), this review demonstrated the relational element runs

throughout. This may be a function of the relational nature of the mental health profession,

which may result in heightened awareness and reflection on relationships.

When participants did discuss the impact of the therapeutic relationships, they often

highlighted the frustrations around the lack of change for clients, rather than exposure to distress.

This supports the conceptualisation of CF in the context of CS, which highlights the importance

of witnessing change and success (Stamm, 2012). Similarly, Debilly, Wright, Varker (2009)

sampled 152 participants and found that work place stress was a better predictor of ST and

burnout than being exposed to others' experiences. Being exposed to distress does not

consistently result in CF (Valent, 2002), and research is yet to understand why some

professionals gain satisfaction from the same work that contributes to CF in others (Sabo, 2006).

Considering this and the eleven papers reviewed, it is possible that for MHP, the overarching

contributor to CF, ST, and burnout is a sense of frustration relating to not being facilitated to do their jobs well, whether this be a result of organisational or personal resources as suggested by Goetz et al. (2010). Valent (2002) proposes that CF relates to a maladaptive stress response to caring, rather than empathy. Therefore, a person can feel 'compassion stress' whereby the caring responsibility results in a sense of burden, exhaustion, and resentment (Valent, 2002). CF may occur when an individual feels they have not adequately cared for others, and results in high levels of distress relating to failure and guilt (Valent, 2002). This model suggests that it is an individual's response to the limitations of their capacity for compassion that accounts for why some professionals are more or less able to manage stress, rather than repeated or prolonged exposure to distress. This again highlights the importance of the physical and emotional resources that are available to MHP in order for them to sustain their compassion.

Clinical Implications

The papers reviewed had varying countries of origin, cultures, and a range of mental health specialists, yet there was considerable agreement in the factors that contributed to CF, ST, and burnout. This suggests that there is a global issue with the systemic factors in which MHP work. Healthcare systems that value curative outcomes and revenue over the quality of care, relationships, and positive team dynamics risk creating environments where employees may find it difficult to maintain their wellbeing, and increase experiences of CF. This may ultimately result in poorer care and outcomes. This review highlights how CF, ST, burnout, and self-care are influenced by management and organisational structures that create environments that are contradictory to therapeutic values and compassion. Furthermore, the participants demonstrated awareness of the impact that their profession was having or could have on them, yet many still

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experienced CF, ST, and/or burnout and were at times unable to implement self-care. This review suggests that MHP had difficulty acting on early signs, and this was related to increasing demands and poor work-place relationships, which in combination created environments where recognising and acting on MHP needs could be challenging. This suggests that awareness at an individual level is not sufficient and for MHP to sustain themselves, awareness and action is needed at an organisational level. There may be an opportunity to influence CF, ST, and burnout by re-addressing targets to reflect MHPs' compassionate values, which may reduce the financial burdens of staff sickness and turnover (Conrad & Kellar-Guenther, 2006). Further research would be beneficial in exploring the links with organisational cultures and CF, ST, and burnout.

Collectively the papers identified ways to prevent or recover from CF, ST, and burnout that have implications for how services might support staff. Finding meaning and having opportunity for success and growth can be fostered by services supporting extra training and involvement in professional networks. Services should prioritise the development of self-care cultures and colleague relationships through protecting time for supervision. Supervision has been consistently identified in the literature as a protective factor in the workplace (Sinclair et al., 2017; Ray et al., 2013).

MHP would benefit from building skills in reflection and being able to set work and emotional boundaries earlier in their career. Many of the participants noted that this was learned through experience, suggesting that there is a lack of awareness or focus on CF, ST, and burnout during training. Increasing awareness and prioritising self-care through education could serve as a preventative measure. New MHP coming into the profession with this knowledge also provide an opportunity to influence the wider culture. Further longitudinal research on the impact of self-

care during early career training would be beneficial for understanding the potential for this to alter wider attitudes around self-care.

Limitations, Strengths, and Future Directions

In using a research appraisal tool (Tong et al., 2007), methodological limitations of the papers reviewed were identified. Primarily papers lacked information on the research team and their interaction with the participants and data, sampling methods, and participant feedback. These methodological issues also limit the reliability of the findings of the current meta-synthesis.

As outlined throughout, there are limitations in the theoretical conceptualisations of CF, ST, and burnout that influence the application of this review. Due to the overlap in the literature, and limited numbers of peer reviewed qualitative research in this area, this review included papers that researched either or all of these concepts. This has the potential to limit this review in theoretically exploring these concepts. However, collating this research has the benefit of exploring participants' experiences of wellbeing in the mental health profession and offering new insight into how these experiences may relate with the literature around compassion and empathy.

Completing this review has demonstrated that along with a theoretical overlap there were significant similarities in experiences, regardless of which concept was under investigation. It is possible that the overlap in both theory and the associated measurement tools is due to each of the concepts being part of a more global characteristic. This would be in line with Stamm's model (2012), which proposes that CF is an overarching term for ST and burnout. However, further qualitative research individually exploring and comparing these concepts as lived experiences may be helpful in further understanding the differences and similarities.

Conclusion

Eleven qualitative papers were reviewed in order to better understand the lived experience of CF, ST, and burnout in MHP. Concurring with the existing literature, the lack of conceptual clarity around the similarities and differences of CF, ST, and burnout was apparent; further exploration is necessary to provide research with a foundation with which to understand the impact of working with distress. Despite this, the papers highlighted some different perspectives, including that CF, ST, and burnout are influenced by factors beyond experiencing others' distress, and that it is significantly influenced by the resources available to MHP. The importance of relationships and support were consistently highlighted. This review suggests that whilst professionals hold some responsibility over their own well-being, in order to support MHP to maintain their compassion and self-care, CF, ST, and burnout needs to be addressed at an organisational and cultural level through values and education.

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Figures and Tables

Figure I Professional Quality of Life Model (Stamm, 2012)
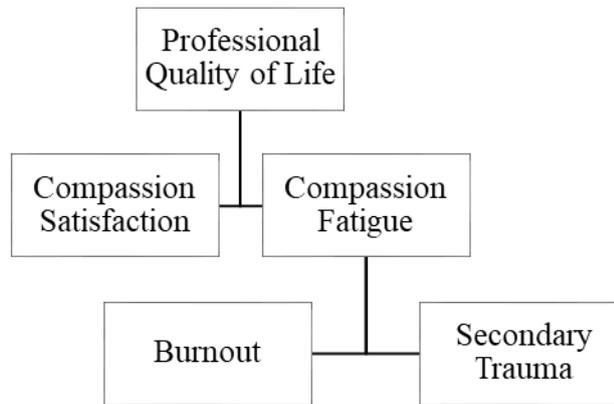
Table I Meta-ethnography (Noblit & Hare, 1988)

Seven-Step Process
1. Getting started
2. Deciding what is relevant to the initial interest
3. Reading the studies
4. Determining how the studies are related
5. Translating the studies into one another
6. Synthesising translations
7. Expressing the synthesis

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Table II Search terms (Cooke et al., 2012)

SPIDER search strategy	Search Terms	Search Field
Subject	(therapist Or counsellor OR psychologist Or "mental health professional")	All text/All Fields
Phenomena of Interest	AND ("compassion fatigue" OR "burnout" OR "burn-out" OR "burn out" OR "secondary trauma" OR "vicarious trauma") AND	Abstract
Design	("Interview*" OR "focus group*" OR	All text/All Fields
Evaluation	"experience*" OR "attitude*" OR "stories" OR	
Research	qualitative OR narrative*)	

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Figure II adapted PRISMA Flow Diagram (Moher et al., 2009)

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│   Records    │ │   Records    │ │   Records    │ │   Records    │ │   Records    │ │  Additional  │
│ identified   │ │ identified   │ │ identified   │ │ identified   │ │ identified   │ │   records    │
│  through     │ │  through     │ │  through     │ │  through     │ │  through     │ │ identified   │
│ searching    │ │ searching    │ │ searching    │ │ searching    │ │ searching    │ │   through    │
│ Scorpus      │ │ PsychInfo    │ │ EMBASE       │ │ MedLINE      │ │ CINAHL       │ │ hand search- │
│ (n=548)      │ │ (n = 536)    │ │ (n=85)       │ │ (n=28)       │ │ (n = 56)     │ │ ing refer-   │
│              │ │              │ │              │ │              │ │              │ │ ences        │
│              │ │              │ │              │ │              │ │              │ │ (n = 11)     │
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│                              Records duplicates removed                                            │
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                        │ Records screened by  │          │  Records excluded    │
                        │ title and abstract   │ ───────► │  (n =538)            │
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                        │ Full-text articles   │          │ Full-text articles       │
                        │ read and assessed    │ ───────► │ excluded as per the       │
                        │ (n = 82)             │          │ inclusion and exclusion   │
                        └──────────┬───────────┘          │ criteria (n = 71)         │
                                   │                       └──────────────────────────┘
                                   ▼
                        ┌──────────────────────┐
                        │ Studies included in  │
                        │ qualitative synthesis│
                        │ (n = 11)             │
                        └──────────────────────┘
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LITERATURE REVIEW

Table III Study characteristics

Reference	Location	Discipline	Study Aims	Methodology/design	Participants	Data Collection	Data analysis	Findings
De Langee & Chigeza (2015)	Africa	Psychology	To explore the strengths that psychologists used to mediate the effects of CF.	Qualitative explorative design	7 psychologists participate, four participants were clinical psychologists, two counselling psychologists and one educational psychologist.	Semi-structured interview	Data was analysed using a narrative approach.	Themes identified that resilience, acceptance, passion, humour and individuals' personal philosophy mitigated CF.
Hanson (2015)	USA	Social Work	To explore the contributing factors to CF and burnout in residential mental health settings.	Mixed-Methods Design using open ended survey questions	66 participants including youth counsellors, therapists, case managers, support workers or school staff	Data was collected online via a mixed-method survey	Qualitative data was analysed using open-coding	CF and Burnout effect client care, professionals and organisations. Themes included quality of work, organisational needs, worker-client relationship, self-care, and organisational support and incentives.
Hernandez-Wolfe, Killian, Engstrom, & Gangsei (2015)	USA	Psychology	To explore the experiences of ST and resilience in professionals working with trauma survivors.	Qualitative grounded theory	13 participants with experience of working with trauma.	Semi-structured interviews were used to collect data.	The data was transcribed and analysed using a constant comparison method.	Working with trauma is both painful and rewarding. Two themes were identified: secondary resilience and secondary trauma. Working with trauma was politically motivated violence and was personally transformative.
Hummelvoll & Severinsson (2001)	Norway	Mental Health Nursing	To investigate MHP's experience of working on a psychiatric ward	Qualitative	16 MHP, 10 of which were mental health nurses and the remaining 6 were therapist and administrators.	Participant observation and semi-structured interview. Field notes were taken from 120 hours of participant observation	Interviews were analysed using qualitative hermeneutic analysis. Field notes were transcribed and coded.	Three themes were coping with uncertainty, caring for patient and coping strategies. The study concluded that support for professionals and organisational structures were important.

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Killian (2008)	Canada	Mental health	To examine the impacts of therapeutic stress on professionals working with survivors of sexual abuse.	Mixed-methods Grounded theory approach	A total of 20 participants, 10 were social workers, two participants were psychologists, four were licensed counsellors, and one was a family therapist.	Semi-structured interview lasting 60 minutes.	Interviews transcribed and coded using grounded theory and constant comparison to create themes.	Professionals experience stress through bodily symptoms, mood and sleep. Self-care included support from peers, supervisors, and family. Themes included: recognising work stress; self-care: definitions and strategies; debriefing or processing; exercise; and spirituality.
Ling, Hunter & Maple (2014)	Australia	Social Work	To explore factors that support counsellors who are exposed to trauma.	Qualitative grounded theory.	18 participants with professional training in counselling and were members of, or eligible to be members of a professional body.	14 individual semi-structured interviews were conducted, and one group interview with 4 participants. Field notes were also taken by the interviewer.	Using a constant comparative method the transcripts were coded into themes	Noticing both positive and negative aspects of work, having support and diverse work help professionals to manage CF working in trauma. These included: thriving in trauma work, navigating empathic journey, empathic stamina and engaging in self-reflexivity.
Lin (2012)	Taiwan	Psychology	To describe self-care and Burnout in Taiwanese university counsellors	Qualitative phenomenology	9 female counsellors working in 5 universities in Taiwan. Participants were selected if they had experienced and recovered from Burnout.	Data was collected using semi-structured interviews that lasted between 90-120 minutes.	Interviews were transcribed and coded using a 6 step method	Recovery requires work-life balance. Four themes included: Burnout is influenced by conflicts between work and family; Burnout is influenced by changes on campus and in counselling profession; self-awareness, self-assessment, and action are key to self-care; and recovery requires the right balance between self, life and work.

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Ohrt & Cunningham (2012)	USA	Counselling	The aim was to collect the perspectives of 10 counsellors about how their work impacts their sense of wellness.	Qualitative interviews and focus groups	10 participants working in mental health services	A demographic questionnaire was used alongside semi-structured interviews lasting between 60-90 minutes. Three counsellors participated in a focus group.	Data was transcribed and anonymized. The author used inductive coding to create themes.	Five themes were identified as important for wellness in the mental health profession: agency resources, time management, occupational hazards, agency culture, and individual differences.
Satkunanayagam, Tunariu & Tribe (2010)	UK	Mental Health	This paper explored experiences of the challenges and rewards of working with trauma in Sri Lanka.	Qualitative.	Participants were 12 MHP working in trauma services.	Semi-structured interviews were conducted with each participant.	Interpretative phenomenological analysis	Professional's experience personal changes as a result of working with trauma and can be both negative and rewarding. Themes included: emotional reactions to trauma work and the costs and rewards of trauma work.
Sim, Zanaedelli, Loughran, Mannarino& Hill (2016)	USA	Psychology	To explore the different experiences of ST, Burnout and coping strategies in early and later career psychologists.	Qualitative	14 participants, half of which early career psychologists and later career stage psychologists.	A demographic questionnaire and 60 minute semi-structured telephone interviews was used to collect the data.	Data was analysed using Consensual Quantitative Research methodology.	There were common factors for Burnout for both early and late career psychologists including tasks and responsibilities and relationships. Only early career psychologists identified accessing personal therapy.
Sui & Padamanabhanunni (2016)	South Africa	Psychology	The aim was to describe the experience and consequences of psychologists working with trauma.	Qualitative phenomenology	Participants were 6 registered psychologist, 4 female and 2 male with at least three years of experience.	Data was collected using semi-structured interviews that lasted 60 minutes.	Thematic analysis was used to create codes and themes.	All participants experienced symptoms of ST and identified factors such as interpersonal relationships, life philosophy and self-perception as important for mitigating ST. Themes included: experiences of vicarious trauma and positive transformations.

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Table 1V Meta-synthesis

Themes/key concepts from original papers	Second-order (researchers') Interpretation	Third-order (reviewer's) Interpretations	Superordinate themes
			Understanding the experiences
Feeling powerless (Satkunanayagam et al., 2010; Sim et al., 2016; Sui & Padamanabhanunni, 2016)	Faced with high levels of distress and challenging work place systems, MHP can feel overwhelmed and unable to help.		
Hopelessness (Satkunanayagam et al., 2010; Sim et al., 2016; Sui & Padamanabhanunni, 2016)	Over time, MHPs experienced hopelessness in response to the lack of change and progress.		
Seeing things differently (Hernandez-Wolfe et al., 2010; Lin, 2012; Satkunanayagam et al., 2010; Sim et al., 2016; Sui & Padamanabhanunni, 2016)	Being exposed to others' experiences of negative events changed MHP experiences of other and the world negatively.	CF causes changes MHPs' perspective of the self, others and the worlds, including their feelings of safety. This negatively impacts on their personal relationships.	Seeing the world negatively
Seeing danger (Lin 2012; Sui & Padamanabhanunni, (2016)	MHP became more aware of danger and experience heightened levels of suspiciousness due to hearing about others negative experiences.		
Not being able to listen (Hanson, 2015; Killian, 2008; Ling et al., 2014 Lin, 2012)	When MHP become overwhelmed they become less able to listen and respond to clients	Experiencing CF may lead to MHP disconnecting or being avoidant of their clients.	Shutting down
			Causes and contributions Difficult professional relationships
Lack of support from peers and supervisors/superiors (Hanson, 2015; Hummelvoll & Severinsson, 2001; Killian, 2008; Lin, 2012; Ohrt & Cunningham, 2012; Satkunanayagam et al., 2010; Sim et al., 2016; Sui & Padamanabhanunni, 2016)	Negative work relationships and not being valued and trusted by supervisors and peers increased work related conflicts and stress, and reduced job satisfaction.	Poor understanding and support of MHPs' therapeutic roles increases experience of CF. This relates closely to others placing demands on MHP and not investing in personal and professional development.	

Number and complexity of cases (Hummelvoll & Severinsson, 2001; Killian, 2008; Lin 2012)	MHP experienced greater levels of case complexity which they have to manage and produce outcomes for with little increase in resources/time which contributes to feelings of stress and delivering insufficient care.	Increased demand due to more complex cases, and less time to work therapeutically increased experiences of CF. This was linked to MHP feeling that the quality of their work suffered and feeling more pressure to achieve unattainable outcomes.	Demands of the role
Less time to do therapy (Hernandez-Wolfe et al., 2010; Killian, 2008; Ohrt & Cunningham, 2012; Sim et al., 2016)	Having to contend with multiple professional roles and high levels of administrative tasks reduced job satisfaction and meaningfulness of professional role.		
Conflicts with family life (Lin, 2012; Sim et al., 2016)	Clashes between work and home life and responsibility increased work stress and emotional exhaustion.		
Not noticing the signs (Hanson, 2015; Killian, 2008; De Langee & Chigeza, 2015; Ling et al., 2014; Lin, 2012; Satkunanayagam et al., 2010; Sim et al., 2016)	Ignoring the early signs of CF resulted in MHP becoming accepting of their negative experiences and exasperated CF.	MHP were able to notice the signs of CF. However, identification of early signs and ability to act on own needs was a risk factor for CF. MHP need to be able to notice the signs of CF early in order to implement strategies for self-care.	Poor self-awareness
			Surviving and thriving
Seeing change, hope and optimism (Killian, 2008; Ling et al., 2014; Satkunanayagam et al., 2010; Sim et al., 2016)	Seeing clients improved is motivating and increased levels of hope in themselves and in other people.	Having opportunities to see the positive impacts of MHPs roles, develop interests through training and supervision is important to help professionals to see and feel valued and motivated reducing the negative effects of CF.	Finding meaning, success, and growth
Professional interest (Hernandez-Wolfe et al., 2010; Ling et al., 2014 Satkunanayagam et al., 2010; Sim et al., 2016)	Having opportunity for training and professionals development maintained positive professional interest and job satisfaction		
Finding purpose and meaning (Hanson, 2015; Hernandez-Wolfe et al., 2010; Hummelvoll & Severinsson, 2001; Ling et al., 2014; Lin, 2012; Ohrt & Cunningham, 2012; Satkunanayagam et al., 2010)	Having a sense of purpose and meaning allowed MHP to better manage negative impacts, engage more with clients and increased job satisfaction.		

Being valued and supported by others (Hanson, 2015; Hummelvoll & Severinsson, 2001; De Langee & Chigeza, 2015; Ling et al., 2014; Ohrt & Cunningham, 2012; Sim et al., 2016; Sui & Padamanabhanunni, 2016) Processing with others (Hummelvoll & Severinsson, 2001; Killian, 2008; De Langee & Chigeza, 2015, Ohrt & Cunningham, 2012; Satkunanayagam et al., 2010; Sim et al., 2016; Sui & Padamanabhanunni, 2016;	Having a mentor/supervisor who invested in MHP professionally and emotionally was important to reduce emotional exhaustion and maintain professional satisfaction and achievement. Supportive family and friends, not experiencing the same stress are important. Having the time and appropriate people to process emotional impacts of the role is important for reducing stress.	It is important for MHP to be able to debrief with others, and this included striking a balance between other professionals experiencing the same thing. Processing with others increases a sense of teamwork and problem-solving	Drawing strength from others
Being able to reflect (Hanson, 2015; Hummelvoll & Severinsson, 2001; De Langee & Chigeza, 2015; Sim et al., 2016) Being able to separate own experiences (Hanson, 2015; Killian, 2008; Ling et al., 2014; Lin 2012; Ohrt & Cunningham, 2012; Satkunanayagam et al., 2010, Sim et al., 2016; Sui & Padamanabhanunni, 2016)	MHP benefit from self-awareness which allows them to monitor their own wellbeing and know their own limitations. It is important for MHP to be able to find a balance between compassion and limiting exposure to emotional content.	MHP need to be able to reflect and be aware of their emotional limits and triggers. MHP need to able to set both emotional and practical boundaries to protect their wellbeing. Actively taking part in and prioritising leisure and time away from work is important for prioritising self-care and maintaining wellness.	Actively taking care of self
Actively doing self-care activities (Hanson, 2015; Killian, 2008; Ling et al., 2014; Lin 2012; Ohrt & Cunningham 2012; Sim et al., 2016)	MHP use a range of leisure and social activities to mediate the negative effects of working with distress.		
Adjusting expectations of self , Hernandez-Wolfe et al., 2010; De Langee & Chigeza, 2015; Lin 2012; Satkunanayagam et al., 2010; Sim, Zanaedelli et al., 2016; Sui & Padamanabhanunni, 2016)	Adjusting personal expectation reduces pressure to succeed and facilitates problem-solving		

Appendix A COREQ

Reporting Criteria	Paper Reference										
	De Langee & Chigeza (2015)	Hanson (2015)	Hernandez-Wolfe et al. (2015)	Hummelvoll et al. (2001)	Killian (2008)	Ling et al. (2012)	Lin (2012)	Ohrt & Cunningham (2012)	Satkunanayagam et al. (2010)	Sim et al. (2016)	Sui & Padamanabhanunni (2016)
Personal Characteristics											
1. Interviewer/facilitator		x	x				x	x		x	
2. Credentials		x	x		x		x	x		x	
3. Occupation		x	x		x	x	x	x	x	x	
4. Gender		x	x				x	x			
5. Experience and training		x	x				x	x			
Relationship with participants											
6. Relationship established	x	x		x				x		x	
7. Participant knowledge of the interviewer				x				x		x	
8. Interviewer characteristics			x	x			x	x		x	
Domain 1: research team and reflexivity total	**1**	**6**	**6**	**3**	**2**	**1**	**6**	**8**	**1**	**5**	**0**
Theoretical framework											
9. Methodological orientation and Theory	x	x	x	x	x	x	x	x	x	x	x
Participant selection											
10. Sampling	x		x	x	x	x		x		x	x
11. Method of approach	x	x		x		x		x	x	x	x
12. Sample size	x	x	x	x	x	x	x	x	x	x	x
13. Non-participation		x		x	x		x		x		
Setting											
14. Setting of data collection		x	x	x		x	x	x	x		x
15. Presence of non participants											
16. Description of sample	x	x	x	x	x	x	x	x	x	x	x

Data collection											
17. Interview guide	x	x	x			x	x	x			
18. Repeat interviews											
19. Audio/visual recording	x		x		x	x	x	x			
20. Field notes				x		x				x	x
21. Duration					x	x	x	x		x	x
22. Data saturation	x			x		x	x			x	x
23. Transcripts returned											
Domain 2: study design total	**8**	**7**	**7**	**9**	**6**	**10**	**9**	**10**	**6**	**8**	**9**
Data analysis											
24. Number of data coders		x	x	x		x	x	x		x	
25. Description of the coding tree							x			x	
26. Derivation of themes	x	x	x	x	x	x	x	x	x	x	x
27. Software		x			x			x			
28. Participant checking	x						x				x
Reporting											
29. Quotations presented	x	x	x	x	x	x	x	x	x	x	x
30. Data and findings consistent	x	x	x	x	x	x	x	x	x	x	x
31. Clarity of major themes	x	x	x	x	x	x	x	x	x	x	x
32. Clarity of minor themes	x			x	x	x	x	x	x	x	x
Domain 3: analysis and findings total	**6**	**6**	**5**	**6**	**6**	**6**	**8**	**7**	**5**	**7**	**6**
COREQ score	**15**	**19**	**18**	**18**	**18**	**17**	**23**	**25**	**12**	**20**	**15**

Note: x indicates the presence of this information

Appendix B Traumatology notes to authors

Manuscript Preparation

Manuscripts submitted to *Traumatology*® should be prepared in accordance with
the *Publication Manual of the American Psychological Association,*
*6*th *Edition* (2010).
Review APA's Checklist for Manuscript Submission before submitting your article.

Formatting
Double-space all copy. Manuscripts should be 30 pages and under (not including
references and tables/figures). Other formatting instructions, as well as instructions
on preparing tables, figures, references, metrics, and abstracts, appear in
the *Manual.* Additional guidance on APA Style is available on the APA Style website.
Below are additional instructions regarding the preparation of display equations,
computer code, and tables.

Tables
Use Word's Insert Table function when you create tables. Using spaces or tabs in
your table will create problems when the table is typeset and may result in errors.

Academic Writing and English De Language Editing Services
Authors who feel that their manuscript may benefit from additional academic writing
or language editing support prior to submission are encouraged to seek out such
services at their host institutions, engage with colleagues and subject matter experts,
and/or consider several vendors that offer discounts to APA authors. Please note
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Submitting Supplemental Materials
APA can place supplemental materials online, available via the published article in
the PsycARTICLES® database. Please see Supplementing Your Article With Online
Material for more details.

Abstract and Keywords
All manuscripts must include an abstract containing a maximum of 250 words typed
on a separate page. After the abstract, please supply up to five keywords or brief
phrases.

References
List references in alphabetical order. Each listed reference should be cited in text,
and each text citation should be listed in the References section.

Figures

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Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.
The minimum line weight for line art is 0.5 point for optimal printing. For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.
When possible, please place symbol legends below the figure instead of to the side.
APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.
The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.
For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:
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LITERATURE REVIEW

You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

Chapter 2 Research paper

What Contributes to Compassion Fatigue in Health Professionals Working in Drug and

Alcohol Services

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Abstract: 256

Main body of text: 8,424

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Abstract

Background: A body of literature has contributed to the understanding of the personal costs of caring for others in distress, how this affects professionals' wellbeing, services quality, and therapeutic outcomes.

Method: This study sought to further understand Compassion Fatigue (CF) and Compassion Satisfaction (CS) by employing existing measures in an online survey of 114 health professionals working in substance misuse services.

Results: The findings showed that 57% of professionals were at risk of CF, and this influenced professionals' intention to remain in post. Approximately 70% of participants experienced sexual harassment, verbal threats, physical violence, or bullying at work and this was correlated with CF ($r= .327$, $p <.001$). Yet, professionals showed positive implicit attitudes towards substance use compared to attitudes towards obesity, and 81% of professionals experienced CS. The perceived strain of working with substance use correlated with CF ($r= .63$, $p <.001$) and CS ($r= -.59$, $p <.001$) with large effect sizes. Emotional suppression and emotion contagion moderated the effect perceived strain of working with substance use has on CF ($\Delta R2 = .052$, $F(1, 80)= 5.62$, $p= .005$). The meaning that professionals ascribe to their roles mediated the relationship between strain and CS ($b = 1.20$, 95% BCa CI 2.01, -55).

Conclusion: On the basis of these findings, services should encourage awareness of the emotional demands of the role and support professionals to understand and develop their emotional skills. To maintain CS, services should focus on fostering or maintaining meaning at an individual and organisational level.

Keywords: *Substance use, Substance Misuse Services, Compassion Fatigue, Compassion Satisfaction*

Worldwide, an estimated 4.5 million adults receive treatment for problems related to drug and alcohol use (WHO, 2012; 2014). The language used to describe drug and alcohol use varies throughout the literature, and has the propensity to stigmatise users as "others" (Broyles et al., 2014). There is diversity in the experiences and societal perceptions of drug use and alcohol use, primarily due to judgements associated with legality and social acceptance (Livingston, Milne, Fang, & Amari, 2012). However, services frequently offer support for both drug and alcohol problems, and the literature, and guidance often refers to both (GOV.UK, 2018). This paper will use the terms substance use to describe alcohol and drug use, and will refer to services as substance misuse services (SMS), whilst acknowledging that not all drug and alcohol use is problematic (Cave et al., 2009).

Attitudes Towards Substance Use

A meta-analysis of SMS found that treatment retention was poor, with one third of participants dropping out (Dutra et al., 2008). Research on service uptake identified that prejudice and stigma from health professionals were the primary barriers for people accessing SMS (Brener, Von Hippel, & Kippax, 2007; Luoma et al., 2007). In a systematic literature review, 28 studies identified that health professionals had negative attitudes, low regard, and little motivation towards working with substance use (van Boekel, Brouwers, Weeghel, Henk & Garretsen, 2013). Perceptions of substance users being violent, 'manipulative' and poorly motivated were found to impede the provision of care (van Boekel et al., 2013). Research identified that service users experienced more stigma from professionals with low levels of specialist experience and education (Earnshaw, Smith, & Copenhaver, 2013), whilst specialist professionals were found to hold more positive attitudes towards substance use (van Boekel, Brouwers, van Weeghel, & Garretsen, 2014).

Research suggests that explicit self-report measures may underestimate negative attitudes, with individuals being unwilling to report, or being unaware of their prejudice

(Swanson, Swanson & Greenwald, 2001). Greenwald & Banaji (1995) proposes that actions or judgments are influenced by automatically activated evaluation. The IAT protocol seeks to understand implicit attitudes by measuring participants' underlying automatic evaluation (Swanson et al., 2001), and research has used implicit attitude measures to identify stigma in marginalised populations, including mental health (Peris, Teachman, & Nosek, 2008) and obesity (Puhl & Heuer, 2009). Despite the reported impact of stigma, few studies have investigated implicit attitudes of professionals in relation to substance use. von Hippel, Brenner & von Hippel (2008) found that negative implicit attitudes were linked to professionals' intentions to leave their job and higher levels of stress. Further exploration of professionals' attitudes towards substance use may contribute to understanding the relationship between stigma and therapeutic relationships.

The Importance of Compassion

The literature on substance use highlights the importance of compassionate approaches in reducing stigma, promoting service uptake, and recovery (Bartlett, Brown, Shattell, Wright, & Lewallen, 2013). In mental health settings research has identified that common factors such as empathy, compassion, and the therapeutic alliance are the primary contributors to positive outcomes (Lambert & Barley, 2001). However, qualities that make professionals effective, such as compassion may have personal costs (Thompson, Amatea & Thompson, 2014).

Compassion fatigue (CF) is a term to describe the reduction in the capacity to respond compassionately as a consequence of repeated or prolonged exposure to another's distress (Figley, 1995). CF has been described in the context of compassion satisfaction (CS), where an individual perceives that their role makes a positive difference; in contrast, CF occurs when a professional feels their role no longer makes a difference (Stamm, 2010). Stamm

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(2012) suggests that if these experiences are not addressed, it can lead to two related experiences: burnout and secondary trauma.

Given the complexity of the therapeutic relationship and compassion, there are considerable variations in definitions of CF (Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski, & Smith-MacDonald, 2017). CF is frequently used interchangeably with the related concepts of burnout and secondary trauma (also referred to as vicarious trauma), which has resulted in a lack of theoretical clarity (Sinclair et al., 2017). In a meta-analysis of the concept of CF within the field of mental health, it was identified that there have been significant challenges in researching professionals' experiences (Sinclair et al., 2017). Acknowledging this challenge, this paper employs the most widely used definition of CF as a preoccupation, inability, or unwillingness to compassionately engage in others' suffering, experienced by those who are repeatedly exposed to other's distress without observing positive change (Figley 1995, 2002). Recognising the conceptual overlap between CF, secondary trauma, and Burnout, CF will be considered an overarching description, encompassing both burnout and secondary trauma (Stamm, 2012, Figure I).

Insert Figure I

Theoretical understanding of Compassion Fatigue

Stress has been conceptualised as a relational `transaction' between individuals and their environment (Lazarus, 1991) that relies on the individual's appraisal of demands which exceed their available coping (Lazarus and Folkman 1986). Similarly, it is suggested in times of stress individuals have limited resources (Figley & Kleber, 1995). Resources for self-regulation taken up in self-initiated and/or situation demands in one area, can result in self-regulation failure in other areas (Vohs & Heatherton, 2000). The conservation of resource theory further suggests that when confronted with distress, individuals seek to protect their

current resources (Hobfoll, 1989). The theory suggests that the loss of resources is psychologically more damaging than acquisition of new ones (Hobfoll, 1989). In a work context, it is predicted that loss of resources has a greater impact than equivalent gains (Halbesleben, Neveu, Paustian-Underdahl, & Westman, 2014). Research has found that individuals are more likely to avoid situations/behaviours where loss is likely to occur (Halbesleben et al., 2014). Therefore, a resource perspective of CF would suggest that working with distress consumes resources, and professionals may become physically and emotionally exhausted (Figley & Kleber, 1995). Professionals may attempt to conserve their resources (Halbesleben et al., 2014) and therefore withdraw their compassion and emotional energy.

CF has also been linked with the emotional contagion, whereby an individual's emotions are positively or negatively mirrored by others (Hatfield, Cacioppo, & Rapson, 1993). It is therefore argued that in being exposed to others' distress, professionals' experience similar affect responses and may become emotionally overwhelmed. Beyond interactions with individuals in distress, the principles of emotional contagion can be applied to services. Research has highlighted the importance of leadership in managing team atmosphere and emotional responses (Ashkanasy & Humphrey, 2011). Leaders who are emotionally intelligent are better at creating a sense of enthusiasm among their group members (George, 2000). In their five-level model of emotions in organisations, Ashkanasy & Humphrey (2011) propose that there is a collective palpable 'emotional climate' and within this there are 'emotional display rules' which set out the boundaries within which the organisation displays emotion. An individual's experience of CF may originate from both their emotional interaction with others' distress and within the context of their organisation (Killian, 2008).

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Research on Compassion Fatigue

The presence of CF in physical health (Neville, & Cole, 2013; van Mol, Kompanje, Benoit, Bakker, & Nijkamp, 2015), mental health (Killian, 2008; Ray, Wong, White, & Heaslip, 2013; Turgoose & Maddox, 2017), and social care (Newell & MacNeil, 2010) settings has been established. CF has long-term impacts on professionals' psychological and physical health and their ability to fulfil their professional roles (Neville, & Cole, 2013; Turgoose & Maddox, 2017). Specifically, CF has a direct impact on the quality of service provision (Lawson, 2007), including the professional's ability to make decisions in the best interests of service users and this can result in staff absence and job turnover (Cocker & Joss, 2016).

The literature has identified risk factors which may increase vulnerability to CF by consuming individuals' resources. Demographic factors including gender, with women being more likely to experience CF than men, age, experience, and low levels of training are associated with increased CF (Sprang, Clark, & Whitt-Woosley, 2007). Working with vulnerable groups such as children was found to be linked to higher levels of CF, with professionals experiencing more intense emotional responses to their difficulties (Sorenson et al., 2016).

The workplace factors and team dynamics also contribute to CF. Longer shifts (Hunsaker, Chen, Maughan, & Heaston, 2015), limited organisational resources, low peer support and demanding caseloads (Sprang et al., 2007) can all increase CF. Quality supervision and consultation (Killian, 2008), team cohesion, and professionals' commitment (Li, Early, Mahrer, Klaristenfeld, & Gold, 2014) tend to reduce CF. A survey identified that job-lifestyle match predicted burnout and that professionals who experienced greater alignment in their personal working styles and values experienced greater CS (Ray et al., 2013).

Hadar, Mathews, and Roberts (2013) highlight the importance of emotional awareness in CF and suggested it increases individuals' ability to regulate emotion and utilise emotional coping strategies. These authors also found that low levels of problem-focused thinking combined with high emotional-focused thinking increased CF, and they suggested that emotional awareness and taking action were important for reducing CF (Hadar, 2013). Gleichgerrcht and Decety (2013) investigated individual traits and coping styles and found that difficulties with regulating emotions increases susceptibility to CF. Psychological inflexibility increased CF in nurses, whilst self-compassion was linked with experiences of CS (Duarte & Pinto-Gouveia, 2017).

Substance Use and Compassion Fatigue

An opinion paper suggested that service users' treatment ambivalence, poor staff training, and lack of supervision create an emotionally challenging work environment which can lead to CF (Fahy, 2007). A survey found that one in five SMS professionals expressed high levels of stress and intended to leave their jobs and that this was linked with low satisfaction, low support, and high workload (Duraisingam, Pidd, & Roche, 2009). Oyefeso, Clancy, and Farmer (2008) found that professionals working with substance use experienced more burnout than other caring professions. This was linked to experiences of alienation from colleagues and clients, high job demand, low control, and case complexity (Oyefeso et al., 2008). However, Farmer (2009) identified that conflicts between work and home life increase stress, yet most professionals maintained their self-efficacy and job satisfaction.

Perkins and Sprang (2013) surveyed 20 SMS professionals in prison and community settings and found that 9 out of 20 scored highly for CF. Participants identified that having personal or family experience with substance use increased experiences of CF, but they also scored higher on CS (Perkins & Sprang, 2013), suggesting that CF and CS capture different aspects of compassion. Depersonalisation and emotional exhaustion were significantly

influenced by working intensively in a methadone clinic, whilst working with a high number

of people with substance use and HIV was associated with less perceived accomplishment

(Shoptaw, Stein, & Rawson, 2000). The authors suggested that the findings were related to

the challenging nature of working with substance use, including the lack of change for this

population and poor supervision (Shoptaw et al., 2000). Experiences of CF were linked with

the lack of trauma training in SMS (Bride, Hatcher, Humble, 2009; Bride & Kintzle, 2011).

Emotional skills such as mindfulness (the practice of noticing and being present), and

individual values were correlated with less burnout and were more predictive than support or

caseload (Vilardaga et al., 2011). In a recent review of 7 publications on CF in SMS, the

prevalence of CF was high (Huggard, Law & Newcombe, 2017). However, the lack of

research focusing solely on SMS settings and the small number of participants were

highlighted, suggesting that further focused research is necessary to understand CF in this

vulnerable group of professionals (Huggard et al., 2017).

Research suggests that professionals' own trauma history, and having similar

experiences to service users, increases CF (Turgoose & Maddox, 2017). SMS often employ

"experts by experience" who have accessed services (Tracey & Wallace, 2016). Individuals'

with their own experiences, and having colleagues who have accessed services, has the

potential to alter SMS professionals' attitudes towards substance use and compassion.

The Current Study

The present research aims to contribute to the literature in SMS and CF by exploring

the impact that workplace factors and individuals' emotional regulation may have on

professionals' experiences of CF. Considering the challenges of working with substance use

(Fahy, 2007), it is possible that CF in SMS may relate to factors specific to working with

substance use. To understand the impact of professional attitudes (van Boekel et al., 2013)

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and how this influences CF, attitudes towards substance use were investigated by self-report questions and a standard IAT protocol (Greenwald, McGhee, & Schwartz, 1998).

It was hypothesised that: (i) SMS professionals will experience CF (ii) this will be influenced by demographic factors and participants' professional and personal experiences; (iii) that negative workplace factors and poorer emotional regulation skills will increase experiences of CF; and (iiii) professionals attitudes towards substance users will effect CF.

Method

This study employed a cross-sectional online anonymous survey using pre-existing quantitative measures, which were presented to SMS professionals. The experiences of CF and CS were measured. The influence of independent variables including demographic variables, case load, personal and professional experiences of substance use, emotional regulation, emotion contagion, and work place factors was also investigated to further understand CF and CS. Based on guidelines, the power required to achieve a medium effect size was a sample size of 108 (Cohen, 1988). The data was collected between the 15th August 2017 and the 14th of February 2018. The appendices relating to study materials are included in Section Four (Ethics) to avoid repetition of material.

Ethics

This research was approved by the Faculty of Health and Medicine Research Ethics Committee (FHMREC) at Lancaster University (Reference: FHMREC 16141).

Participants

Participants were recruited through the research teams' professional contacts, by contacting relevant services, and advertising with non-NHS professional special-interest networks and social media groups. Snowball sampling was also taken advantage of, as professionals offered to distribute the study to their colleagues.

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Inclusion Criteria

Participants were included if they were health professionals working in SMS with a minimum of three months' experience and direct contact with substance use. Participants were asked to indicate how long they had worked in SMS to establish whether CF was something that was developed overtime or an immediate experience. Participants were included if they held paid or unpaid/voluntary contracts, reflecting the frequent employment of peer mentors and "experts by experience" within SMS (Tracey & Wallace, 2016). All participants were aged 18 or over and were English speaking.

Materials

The e-survey measures are included in Section Four, Appendix C of this thesis to avoid repetition of material.

Demographic information. Demographic information, including age, gender, and level of experience, education and case load was collected. To establish the influence of personal experiences and to reflect the frequent employment of "experts by experience" within the drug and alcohol sector (Tracey & Wallace, 2016), participants were asked whether they had experienced a drug or alcohol problem.

Measures of Compassion Fatigue. The Professional Quality of Life (ProQOL) Version 5 (Stamm, 2010) is a widely used and validated measure of CF and CS, and includes three scales on CS, burnout and secondary trauma/CF. The wide use of the ProQOL has demonstrated good construct validity and reliability (Cronbach's α =0.89, Stamm, 2010).

Workplace Factors. To further understand which work related factors may influence compassion, the Copenhagen Psychosocial Questionnaire II short questionnaire (COPSOQ-II) was used (Kristensen, Hannerz, Høgh, & Borg, 2005). The COPSOQ II

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benefits from breaking down work place influences into a number of domains (Kristensen et al., 2005). Questions relating to negative events at work record experiences of sexual harassment, threats, violence, and bullying (Kristensen et al., 2005). The internal consistency of the scales is high with Cronbach alpha ranging between 0.59 and 0.89 (Kristensen et al., 2005).

Measures of Emotional Regulation Skills. The Emotional Regulation Questionnaire (Gross & John, 2003) samples professionals' emotional skills and offers scales on emotional suppression and cognitive reappraisal. The measure demonstrates adequate reliability (Cronbach's α =79 for cognitive reappraisal and α =.73 for emotional suppression (Gross & John, 2003). To measure how participants' environment and the experiences of others impacted on their emotional experiences the Emotional Contagion scale (Siebert, Siebert, & Taylor-McLaughlin, 2007) was used. In a large sample this scale demonstrated good reliability (Cronbach $\alpha = 0.90$) and construct validity (Siebert et al., 2007).

Measures of Attitudes Towards Substance Use. Participants' explicit attitudes towards substance use, specifically "working with drug/alcohol users is really a strain for me", and their intention to remain in post was assessed using questions adapted from von Hippel et al. (2008) (Appendix C, ethics section). An online IAT facilitated by Carpenter et al. (2018) sampled implicit attitudes towards substance use by assessing the association between a target-concept (substance use) and evaluation (compassion). The standard IAT protocol, completed on a computer, involves an initial trial where participants quickly categorize the target concepts and a control concept by pressing one of two keys on a keyboard. Following this, words representing an evaluation are categorized. In the following trails, the target concepts are paired with evaluations. Participants are required to correct errors they make, and the response times are measured. Faster response times indicate that

participants associated the pair more easily and therefore indicate their implicit attitudes

(Greenwald et al., 2003). Appendix A offers a visual example of an IAT trial.

To make the IAT accessible to an online format, it was necessary to use pre-existing

software, and due to limited funding, a single target (e.g. substance use only) IAT was not

available. Given the social and psychological complexity of substance use (Luoma et al.,

2007), identifying a second target was challenging. After discussion, the research team

agreed that obesity was an appropriate control group. Research using an Implicit Attitude

Test (IAT) found that specialists working with obesity have an implicit bias against people

they work with and identified that more experience and direct contact with this population

reduced implicit bias (Budd et al., 2011). Similar to substance use, obesity has both

psychological and physical causes and consequences. Obesity is a stigmatised health

condition, perceived as being a consequence of an individual's life style and under personal

control (Budd, Mariotti, Graff, & Falkenstein, 2011). Therefore, by assessing whether

levels of negative implicit attitudes towards substance use were similar or different to

attitudes towards obesity, comparisons can be made between SMS professionals' attitudes

with the existing literature on obesity (Budd et al., 2011).

Insert Table I

Data Analysis

Each survey was scored in its relevant subscales, and descriptive statistics were

calculated. Research suggests that the scales of burnout and secondary trauma on the ProQOL

benefit from being merged to reflect the conceptual overlap (Heritage, Rees, & Hegney,

2018). Heritage et al. (2018) recommend their own restructured version of the measure.

However, given that the ProQOL has been used extensively, the scores for secondary trauma

and burnout scales were combined to create a total CF score. To address hypothesis (i) that

SMS professionals will experience CF, both scorings were used. This allowed for comparison

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with the existing literature, whilst reflecting the emerging evidence that these concepts

overlap.

To address the hypotheses that personal and professional experiences (ii) and

workplace and emotional regulation skills (iii) will influence CF, correlation analysis and

Cohen's (1988) interpretation of effect sizes (.1 = small, .3 = medium, .5 = large) were used

to establish the strength of relationships between independent variables and CF and CS. The

stress and burnout subscales on the COPSOQ-II were not included in the analyses due to

multicollinearity issues with CF (the shared variance between CF and stress was 49% and

burnout 38.5%). Following this appropriate level tests examined demographic differences in

relation to compassion, personal experiences of substance use, negative work experiences,

and the implicit attitudes scores. Standard levels of significance were reported ($p < 0.05$). To

investigate the predictors of compassion, step-wise multiple regression and exploratory

moderation and mediation analysis (using PROCES version 2, Hayes, 2013) were conducted.

To establish whether professionals' attitudes towards substance users will affect CF

(hypothesis iiii) the IAT was analysed using the application provided by Carpenter et al.

(2018) which employs the algorithm described by Greenwald, et al. (2003). The difference or

similarity in average latency between reaction times for each target is measured and

represents participants' implicit attitudes. This yields a D-score; a positive D value indicates

positive bias to target A (e.g. substance use) (Greenwald et al., 2003).

Results

A total of 142 participants accessed and started the survey. Participants' data sets

were included if they responded to 95% or more of the survey questions, resulting in 114

participants being included in the analysis. Of the included sample, 93 participants completed

the IAT. Demographic data is displayed in Table II. The majority of the sample was female.

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64% had obtained an undergraduate degree or above and 39.9% of participants reported

having had a personal experience of drug or alcohol problems.

Insert Table II

Levels of Compassion

On the sub-scales of the ProQOL, the sample scored a mean of 37.28 (SD= 6.15) on

CS, 25.80 (SD =6.19) burnout, and 22.92 (SD= 5.74) on the CF/secondary trauma scale. The

combined (burnout and secondary trauma/CF) mean for CF was 47.47 (SD = 10.75).

According to the manual, scores above 33 indicate compassion satisfaction (Stamm, 2010).

Participants scoring above 22 on burnout, and 17 or above on secondary trauma scale would

be classified as experiencing negative experiences (Stamm, 2010). Therefore, it is indicated

that 81% of the current sample were experiencing CS, 70% scored 22 or above for burnout,

and 78% scored 17 or above on CF/secondary trauma. Of 114 participants, 57% SMS

professionals scored above the thresholds for both the burnout and CF/secondary trauma

subscales.

Demographic Analysis

Table III shows the significant statistical analysis and effect sizes for the demographic

variables. Significant gender differences were observed in emotional suppression (df= 107, t=

2.07, p= .041), with men scoring higher than women. Men scored higher than women in their

perception of strain (df= 106, t=2.93, p= .013), and the quantitative work demands (df= 107,

t= 2.48, p= .015). There were no significant gender differences for CF or CS. There was no

significant difference in length of experience and CF (df= 89, F= 2.86, p= .084) or CS (df=

99, F= .494, p= .687). Participants with an education level above university degree

experienced less CF (df=89, t=-2.36, p= .021) and emotional demands (df= 106, t=-3.47, p

<.001) than those with education levels below university degree. However, having higher

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education reduced role predictability (df= 104, t= 2.66, p= .009). Having a personal experience of substance use decreased CF (df= 92, t= 2.12, p= .037), with medium effect size and emotional contagion (df=105, t= 3.39, p <.001) with a medium to large effect size.

Insert Table III

Negative Events in the Workplace

70% participants had experienced one or more experience of sexual harassment, verbal threat, physical violence, or bullying at work. 35% experienced more than one negative experience. The distribution across different types of experience is shown in table IV. Further analysis of the types of experience revealed no significant differences for the means scores of CF, CS, or intention to leave their jobs. However, an ANOVA identified significant differences for CF between professionals who had experienced negative events and those who had not (df= 89, F= 4.30, p= .017). The mean CF scores were significantly higher (-7.45, p= .001) for those experiencing more than one negative work event compared to participants who reported no negative work events, with a medium to large effect size (d= .69).

Insert Table IV

Emotional Regulation Skills

Table V shows that CF and CS were correlated with emotional skills. The results range from medium to large effect sizes. Emotional suppression was positively correlated (r= .43, p= .001) with CF. CF negatively correlated with CS (r= -.33, p <.001). Cognitive reappraisal skills were negatively correlated with CF (r= -37, p <.001) and positively with CS (r= .43, p <.001). Similarly, emotional contagion was positively correlated with CF (r=.39, p

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<.001) and negatively with CS (r= .43, p <.001). Cognitive reappraisal and emotional

contagion were significantly negatively correlated (r= -.36, p <.001).

Insert Table V

Attitudes Substance Use

The IAT showed that participants had significantly (df= 90, t= 6.24, p <.001) different

implicit attitudes towards substance use stimuli in comparison to obesity, with a medium to

large effect size (d= 0.65). Participants showed a preference for substance use stimuli

signified by positive d-score (d-score M=.28, d-score SD= .43). IAT scores negatively

correlated with intention to leave (r= -.28 p= .008), with a small effect size. The explicit

attitude measure did not correlate with the IAT, CF, or intentions to leave.

Table V shows that the perceived strain of working in SMS was correlated positively

with CF (r= .63, p <.001) with a large effect size, emotional suppression (r= .20, p= .038),

emotional contagion (r= .24, p= .022) and participants' intention to move jobs (r= .29,

p= .002) with a small to medium effect sizes. Workplace strain correlated negatively with CS

(r= -.59, p <.001) with a large effect size and cognitive reappraisal (r= -.27, p= .004) with a

medium effect size. The direction of the correlations (Table V) suggest that higher perceived

strain of working with substance use was related to increased suppression and decreasing

cognitive reappraisal, and that this was associated with CF and CS.

Work place strain correlated significantly with a number of questions in the

COPSOQ-II and significantly correlated with CF and CS (Table VI). Strain related to

working with substance use and a number of the scales on the COPSOQ-II were also

significantly correlated with emotional suppression and emotional contagion (Table VI).

Insert Table VI

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Predicting CF and CS

Given the large number of variables in the COPSOQ-II, a stepwise multiple regression evaluated whether strain and workplace factors predicted compassion. The assumptions for multiple regression were met. At step one of the analysis, strain entered into the regression equation and was significantly related to CF, $F_{(1, 76)} = 52.69$, $p < .001$. The multiple correlation coefficient was .64, explaining 41% of the variance of the CF. Following strain in sequential order, work/family conflict $F_{(2, 75)} = 46.52$, $p < .001$; meaning $F_{(3, 74)} = 46.35$, $p < .001$; health $F_{(4, 73)} = 39.27$, $p < .001$; quantitative demands $F_{(5, 72)} = 34.29$, $p = .009$; and finally development $F_{(6, 71)} = 31.02$, $p < .001$ were entered into the regression to create a final model ($r = .85$) explaining 72% of the variance of CF. In a second stepwise multiple regression for CS all assumptions were met. Meaning entered in step one to predict CS $F_{(1, 81)} = 84.34$, $p < .001$ with a correlation coefficient of .71, explaining 51% of the variance. In step 2, strain entered the model $F_{(2, 80)} = 65.91$, $p < .001$, $r = .78$, explaining 62%, and in step 3 commitment was entered $F_{(3, 79)} = 57.86$, $p < .001$, $r = 83$ explaining 69% of the variance. For both CF and CS strain emerged as a predictor. Further multiple regression analysis was used to investigate the influence of emotional skills on strain and compassion (Appendix B).

Moderation and Mediation Analysis

Given that emotional and workplace variables were correlated with both CF and CS, mediation and moderation analysis was completed. Moderation analysis identifies whether the size of an association between two variables is influenced by another variable(s) (Hayes, 2012). For CF, a significant model was identified for the relationship between strain and CF with emotional suppression and emotional contagion acting as moderators, $F_{(5, 80)} = 26.99$, $R^2 = .63$, $p < .001$ (Figure II) explaining 63% of CF. In the first interaction (emotional suppression x strain), there was significant R^2, $\Delta R2 = .025$, $F_{(1, 80)} = 5.40$, $p = .023$,

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indicating a significant moderation of emotional contagion on the relationship between strain and CF, b= .48, SE = .21, t(80)= 2.32, p= .023. A second interaction (emotional suppression x strain) was also significant R2, ΔR2 = .026, F (1, 80) = 5.52, p= .021, demonstrating that emotional contagion moderated the effect of strain on CF, b= .32, SE = .14, t(80)= 2.35, p= .021. The interaction of both (emotional contagion x strain and emotional suppression x strain) R2, (ΔR2 = .052, F(1, 80)= 5.62, p= .005), suggested that emotional suppression and emotional contagion increase the effect of the strain of working with substance use on experiences of CF.

Insert Figure II

The conditional effects indicated that higher emotional suppression and emotional contagion levels increased the effect of strain on CF, b = 8.17, SE = 1.17, 95% CI [5.84, 10.51], t(80) = 6.6, p < .001. Conversely, higher emotional regulation (low levels of emotional suppression and emotional contagion) did not moderate strain and CF, b = 1.64, SE = 1.24, 95% CI [-.85, 4.21], t(80)= 1.31, p= .192. Figure III illustrates the conditional effects of emotion on low, medium, and high average scores of strain and shows that the higher the average strain score, the more emotional suppression and emotional contagion moderates the effect on CF.

Insert Figure III

For CS, moderation analysis was not significant. Alternatively, mediation describes how an independent variable can have a direct effect and indirect effect through other variables on the dependent variable (Hayes, 2012). The relationship between strain and CF was mediated by meaning (COPSOQ II). Figure III illustrates the mediation model and the significant standardised regression coefficient between strain and CF, and strain and

meaning. There was an indirect effect of strain on CF mediated by meaning, $b = 1.20$, 95%

BCa CI (2.01, -55). A Sobel test (Hayes, 2013) indicated that cognitive reappraisal $b= -.079$

$p= .51$ and emotional suppression $b= .086$, $p= .390$ were not significant mediators of strain

and CF. The results indicate that when participants experienced more meaning in their work

this increased CS.

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Discussion

As hypothesised, the current results have identified that working with substance use

has an impact on professionals' compassion and CF and CS was related to work-related

factors and levels of emotional suppression and contagion. Although implicit attitudes to not

significantly influence CF or CS; as hypothesized explicit attitudes, specifically the

perception that working with substance user creates strain, was significantly correlated and

predictive for both CF and CS. The relationship between perceived strain and CF was

moderated and increased by emotional suppression and emotional contagion. Experiencing

meaning mediated the effect of strain on CS. Furthermore, the findings suggest that a large

number of SMS workers experience sexual harassment, threats, violence and bullying in the

workplace and that experiencing more than one of these was likely to increase CF.

The results indicated that 81% of SMS professionals experienced CS and 57% were at

risk of CF. In comparison, 54% of doctors (Markwell & Wainer, 2009), 27.3% of trauma

nurses (Hinderer et al., 2014), 16% of psychiatrist, and 24% of social workers (Rossi et al.,

2012) experience CF indicated by the ProQOL in other studies. This suggests that

professionals working in SMS are at an increased risk of experiencing CF compared to other

caring professions. There were no significant interactions between length of experience

working with substance use and experiences of CF and CS in the current sample. This

suggests that CF may not require exposure to distress over time, as suggested by Figley

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(2002). Alternatively, it is possible that CF could be a more immediate experience in SMS. However, only eleven participants had less than 5 years experiences, and further research with a larger sample is necessary to understand the influence of experience of CF.

Compassion Fatigue in Substance Misuse Services

The influence of workplace factors and emotional skills on CF can be understood in the context of both resource depletion (Figley & Kleber, 1995) and emotional contagion (Hatfield et al., 1993). Working with substance use puts strain on SMS professionals and this is a strong predictor of CF. As suggested by Fahy (2007), it is possible that people with substance use present challenges that impact CF, for example in retaining people in services (Dutra et al., 2008), as well as violence and motivational issues (van Boekel et al., 2013). Typically people with substance use have more unmet psychological, social and physical health needs than some other populations and consequently they frequently require a high level of care co-ordination (Pringle, Emptage, & Hubbard, 2006). Working with this population may require more emotional and physical resources, which may increase the likelihood of these becoming depleted. Figley (2002) emphasised the importance of witnessing positive change, and it is possible that due to the challenges faced, SMS professionals witness low levels of change and experience greater depletion of their own resources.

The results suggest that 70% of professionals experienced sexual harassment, threats, violence and/or bullying in the workplace and that the source of these negative experiences was predominantly from service users. A psychodynamic perspective suggests that difficult or verbally/physically aggressive service users may evoke helplessness, contempt, avoidance or attempts to placate in professionals and it may be that much more challenging to maintain empathy (Groves, 1978). The high rate of negative events, safeguarding and legal responsibilities of professionals (Fahy, 2007) is also likely to create conflict within

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therapeutic relationships. The literature suggests that professionals' personal history of trauma/distress can increase CF due to increased experience sharing (Nelson-Gardell, & Harris, 2003; Kassam-Adams, 1995). Research has identified that working in a high risk environment increases hypervigilance (Somer, 2008) which has the potential to further deplete individuals' resources. SMS professionals who experience abuse and threats of abuse from colleagues and/or superiors may have decreased support within the workplace, something which has been identified as a protective factor for CF (Turgoose & Maddox, 2017). Work environments with abusive relationships are also likely to create a negative emotional climate which may increase CF. Despite the magnitude of these experiences reported, there remain gaps in the literature and this warrants further exploration.

Work Environment

In concordance with the existing literature (Ray et al., 2013; Sprang et al., 2007; Thompson et al., 2014), negative workplace factors were associated with CF. These could deplete individuals' resources by loading onto the existing physical and emotional demands of working with distress. Equally, negative workplace factors could affect the emotional climate of SMS (Ashkanasy & Humphrey, 2011) and promote negative attitudes which could impact on individuals (Killian, 2008). Further analysis highlighted that work/family conflict, meaning, health, quantitative demands, and development were predictive of CF. Work/family conflict on the COPSOQ-II included how much work "drains" respondents and affects their private lives (Kristensen et al., 2005). This suggests that working with substance use may deplete resources to an extent where it affects the home lives of professionals. Experiencing a conflict between work and home may provide less opportunity for self-care, and place strain upon relationships which offer support (Killian, 2008). The finding that general health affects CF may also relate to individuals' physical and emotional resources for carrying out their role in a compassionate way (Figley, 2002). The quantity of SMS professionals' case and

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workloads is also important in predicting CF, a finding that is consistent within the existing

literature (Ray et al., 2013). However, in the current study caseload itself was not

significantly correlated with CF. Alternatively, the questions on the COPSOQ-II relating to

perceptions of being behind and/or overwhelmed by job responsibilities were correlated. This

may be a more relevant predictor of how job demands affect CF, in that it relates to the

perceived burden of the work rather than the quantity. Finally, professional development

captures the opportunity to take initiative and learn, and being unable to do so may increase

frustration and impact on the perceived value being placed on them and their roles by their

organisation (Ling et al., 2014).

Emotional Factors

Strong relationships were found between participants' emotional skills, CF and work

factors, supporting the existing research (Gleichgerrcht & Decety, 2013). Focusing on strain

as a variable specific to working with substance use, increased emotional suppression and

emotional contagion were significant moderators of CF. Therefore, professionals who

experienced strain and who were avoidant of their emotion, were at a higher risk of CF. This

reflects previous findings that maladaptive coping styles, such as denial, predicts burnout

(Thompson et al., 2014). In one study, suppressing emotional expression was cognitively

distracting, and was associated with poorer expressive and receptive communication and

higher levels of stress (Butler et al., 2003). It is possible that when suppressing emotions,

professionals are less able to process the impacts of working with substance use. In being less

able to process the emotional effects, professionals may be less likely to seek out support or

put in place self-care strategies.

Similarly, SMS professionals who perceived high levels of strain and were more

susceptible to the impacts of their emotional environments, experienced increased CF.

Negative emotional contagion can contribute to negative bias (Rozin & Royzman, 2001) and

therefore may contribute to SMS professionals being unable to notice positive change or value within their work. It is possible that these individuals are also more likely to experience heightened emotions when faced with the challenges of working with substance use and witnessing their distress. The correlations between negative workplace and emotional variables may be indicative that some individuals are more emotionally susceptible to negatively experiencing their wider work environment.

Thomas (2013) investigated components of empathy and identified that personal distress and individuals' ability to regulate this were the best predictors for CF. Thomas (2013) suggests that emotional regulation is important in order for professionals to successfully engage empathically with others' distress whilst separating these experiences from their own and maintaining a sense of self. Therefore, those with higher emotional suppression and emotional contagion may be less resourceful in order to engage emotionally with others and be less able to maintain necessary emotional boundaries to prevent further emotional contagion.

The results may link with research which has identified the role of internal locus of control in moderating CF (Injeyan et al., 2011). Externally oriented professionals are more vulnerable to CF and this could be due to experiencing less control over outcomes and may be linked with higher anticipatory anxiety (Injeyan et al., 2011). Potentially, professionals who experience CF and have high levels of emotional contagion, experience less emotional control and learn to suppress their emotions as a coping mechanism. Together emotional contagion and emotional suppression may result in professionals feeling helpless and dis-empowered in managing their own experiences.

Attitudes towards Substance Use

Substance use was compared against obesity in order to draw on the existing literature which identifies that professionals can have negative implicit attitudes (Budd et al., 2011).

These results suggest that SMS professionals are less stigmatising towards their services users than professionals working with obesity (Budd et al., 2011). In contrast to the hypothesis, these scores were not significantly correlated with CF, but were negatively correlated with intention to leave in concordance with research completed by von Hippel et al. (2008). However, the existing literature on explicit attitudes suggests that substance use is highly stigmatised by professionals (van Boekel et al., 2013). The current results may reflect the sampling strategy which recruited specialist SMS professionals rather than general health professionals and supports that specialist SMS professionals may have less negative attitudes towards substance use (van Boekel et al., 2014). Furthermore, 39.9% of participants had personal experiences of substance use, and this was associated with decreased CF. Having personal experiences and/or being in contact with colleagues that do, may reduce negative attitudes towards substance use by increasing identification and also hope and optimism that recovery is possible.

Compassion Satisfaction in Substance Misuse Services

CS was predicted by strain, suggesting that those who do not view people with substance use as putting a strain on them, experienced more satisfaction. Whilst CS was also affected by professionals' work environment, correlating with a number of scales on the COPSOQ-II, meaning emerged as the best predictor. It is possible that in perceiving less strain, professionals are better able to derive meaning and CS from their work. In the existing qualitative research, feeling hopeless contributed to CF, whilst finding meaning and hope mitigated it (Ling, Hunter, & Maple, 2014). The oxford dictionary definition of satisfaction includes "fulfilment of one's wishes, expectations, or needs". Despite the personal costs, many people enter into caring professions with an interest in helping others (Collins & Long, 2003). However, working in a challenging environment such as SMS (Fahy, 2007), where success can

be rare (Dutra et al., 2008), it is possible that finding meaning becomes the need that is fulfilled in CS. Therefore, in the absence of witnessing overt positive change, being able to identify meaning may support SMS professionals to believe that their roles are important and making a difference, thus supporting CS (Figley, 2002). Furthermore, a survey with a small sample Perkins & Sprang (2013) found that personal or family experience with substance use increased personal fulfilment and that these professionals approached their careers as a "calling", which suggests that this factor may have made the work more personally meaningful to them.

The finding that meaning mediates the relationship between strain and CF could relate to research that suggests optimism reduces CF (Injeyan et al., 2011). The authors propose that optimistic professionals may engage in more active self-care and problem solving, and less self-criticism (Injeyan et al., 2011). Being able to identity meaning in work may have similar effects to optimism in allowing professionals to be more positive and proactive in their roles. Therefore, it is possible that finding meaning in the workplace contributes to an individual's emotional resources.

It is possible that experiencing less strain and more meaning allows SMS professionals to have more emotional resources. In the existing literature, higher levels of mindfulness and "emotion-focused coping" have been shown to predict lower levels of CF (Thompson et al., 2014). In line with this, research has found that being attentive to personal distress, actively engaging in self-care (Killian, 2008) or practice self-compassion (Duarte & Pinto-Gouveia, 2017) increases CS. Therefore, having more emotional resources to notice and address issues may provide greater opportunity for self-care and reflection on the positive, meaningful, or rewarding aspects of professional work, resulting in CS.

Clinical Implications

Without intervention, SMS workers are at a risk of high job turnover, unstable teams, and the loss of skills and knowledge (Cocker & Joss, 2016). Given that the perceived strain of

working with substance use was a significant predictor for both CF and CS, it is important that professionals entering into the profession do so with knowledge of the challenges of working with this population and the emotional resources it requires. As SMS are multi-disciplinary - including nursing, social work, psychology and individuals with no professional alignment (Huggard & Newcombe, 2017), it may not be possible to provide specific training before employment. It is then important that individuals' understanding of the emotional resources is assessed and developed during the interview and early stages of their career. The significance of work-life fit has been established (Ray et al., 2013), and in supporting and training professionals there is an opportunity for individuals to assess the "fit" of their roles. Investing at this point may reduce the perception of strain and be a preventative measure for CF, reducing staff turnover and creating more stable work environments.

As well as assessing 'fit', it is also important that organisations reduce CF by improving the work environment in order to increase the physical and emotional resources available to individuals. It is important to acknowledge that a number of professionals in this sample experienced sexual harassment, threats, violence and bullying. Further research is necessary to understand what the causes of these experiences are, how professionals process these, the impact it has on them, and the supports that are in place around it. Given the prevalence, it is important that services address this with their staff and make sure that the appropriate support is in place.

Alkema, Linton, and Davies (2008) studied self-care and CF in healthcare professionals and found that supporting them to find meaning and rewards mitigated CF and maintained CS. Meaning may originate from the reasons individuals entered the profession including professional interest, personal experience and wanting to help, as well as internal psychological factors such as optimism (Injeyan et al., 2011). To remain compassionate, SMS professionals need to be supported to remain in touch with or seek out new values which sustain the

importance they ascribe to their role. Services should consider how to sustain meaning through rewards and investment by offering professional development and training.

There has been debate in the literature between the differences between CF and countertransference, with some arguing that CF requires self-care rather than supervision (Berzoff & Kita, 2010). However, the current findings highlight the importance of emotional coping in both CS and CF. It is likely that self-care alone may not address emotional suppression and emotional contagion, suggesting that individual supervision should facilitate recognition of these issues and coping strategies. At an individual level, interventions for CF and burnout have focused on developing or strengthening self-awareness through supervision, peer support, and mindfulness (Kearney et al., 2009).

Given the importance of supervision and peer support (Maslach, Schaufeli, & Leiter, 2001) and the current findings on emotional suppression and emotional contagion, services should be vigilant for attitudes amongst teams which may create negative emotional climates. Promoting awareness and self-care within teams may work towards creating positive work environments which give rise to a less negative emotional atmosphere (Killian 2008), and could reduce emotional contagion. Practices such as peer and group supervision, case discussion, and team formulations can support teams in developing a reflective culture and a supportive emotional climate. Research has found that team formulation is a powerful tool in reducing negative attitudes towards service users and maintains hope (Hollingworth & Johnstone, 2014), which may reduce CF and increase CS.

Study Limitations

This study yielded a wealth of data and due to scope, the aims analysis was focused primarily on factors specific to SMS. The study addressed a number of dependent and independent variables, and whilst this has value in collecting a vast amount of exploratory data which can highlight unexpected interactions and relationships, introducing a number of

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variables can compromise the power and validity of the results. Although the target number sample was achieved for a medium effect size, the results of the current study would benefit from being replicated with a larger sample. The measures used in the current study included a number of conceptual overlaps. For example, wording such as "worn out" and "stressed" in the COPSOQ-II have conceptual overlap with CF. Although variables that had considerable shared variance (e.g. stress and burnout) were removed from the analysis, it is possible that the strength of the results, and therefore the interpretations based on these, is due to conceptual overlaps with CF and individual questions. Other measures of workplace experiences may have offered less overlap. These methodological issues reflect the lack of conceptual clarity around CF discussed below, and further research needs to focus on clarifying these overlaps to inform the development of conceptually sound and ecologically valid measures. Furthermore, in interpreting a large amount of data, important clinically relevant information can get lost; the topic area would benefit from more in-depth research into each hypothesis undertaken in the current study.

Comparisons were made between the current results and the existing literature on CF and CS. However, these studies used a variety of instruments or previous versions of the ProQOL and therefore the interpretations have to be made with some caution. Within the literature it is acknowledged that there is a lack of conceptual clarity around CF and related terms of burnout and secondary trauma (Sinclair et al., 2017). Subsequently, comparison with the existing literature, which varies in its conceptualisation of CF, is challenging (Sinclair et al., 2017). When comparing the prevalence of CF and CS, the original scales on the ProQOL were used. However, this study also took into account recent findings that there was considerable shared variance in the burnout and secondary trauma/CF scales on the ProQOL (Heritage et al., 2018) and recent reviews of the theory and concepts behind CF (Sinclair et al.,

2017) by combining the CF and burnout scores. Combining these scores may change the validity of the ProQOL (Stamm, 2010) and may not be comparable to the existing literature.

To get the most responses from the widest population, the survey was distributed online which created some challenges when it came to embedding the IAT. At the time that the study was completed, it was only possible to use a standard IAT protocol within the survey software. It was therefore necessary to identify a logical and conceptually related comparison group (Greenwald et al., 1998). Theoretically, obesity is a similar health-related experience with both physical and psychological aspects, and there is an established body of research on the presence of stigma using IAT protocols (Budd et al., 2011). However, it is possible that the results of the IAT were skewed due to the comparison group not being equivalent to substance use, and further research into professionals' implicit attitudes towards substance use is necessary.

Of the people who started the survey (progressed past participant information), 80% completed. However, 93 people accessed the survey via the link but did not start it, dropping the response rate to 48%. Participant feedback suggested that a potential barrier was the use of the IAT which prevented participants from completing the survey on mobile devices, and it is possible that the conclusions of this study are not generalizable to the wider SMS. There was also considerable self-initiated positive feedback from participants about the importance of this research, and it is possible that experiencing CF meant people were more likely to complete the survey. Alternatively, SMS professionals experiencing high levels of CF may have chosen not to participate due to the time implications adding further strain. This could lead to potential biases in the results.

Conclusion

The results suggest that 57% of SMS were experiencing CF and in concordance with the existing literature, CF and CS was related to workplace and individual emotional factors. The relationship between perceived strain of working with substance use and CF was

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moderated by emotional suppression and emotional contagion, suggesting that professionals who experienced strain, were avoidant of their emotion, and highly influenced by others, were at a higher risk of CF. The amount of strain that participants experienced mediated the attribution of meaning, and this affected CS. Given the prevalence of CF in SMS, it is important that professionals are supported to understand the emotional demands and resources of the role and to build reflective skills which allow them to manage their emotional responses and identify positive meaning. At an organisational level, teams need to be supported to create and maintain positive emotional climates which facilitate hope, belief and self-care practices.

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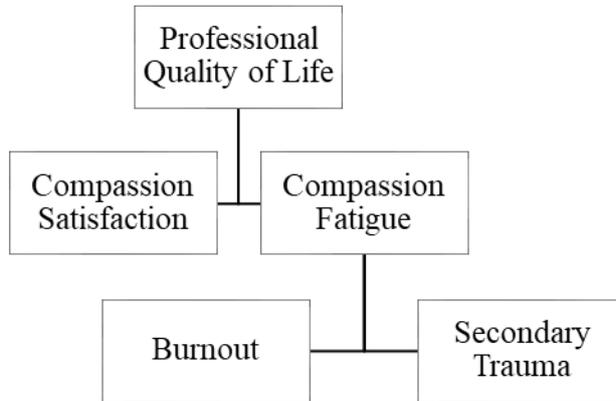## Figures and Tables

Figure I Professional Quality of Life Model (Stamm, 2012)

Table I IAT Descriptive terms

	Descriptive Terms
Target A (substance use)	Drug User, Substance Abuser, Drug Addict, Alcoholic, Drinker, Addiction
Target B (obesity)	Fat, Obese, Overweight, Heavy, Morbidly Obese, Large
Evaluation A	Good, Affection, Care , Grateful, Warmth, Hopeful, Considerate, Understanding, Protective
Evaluation B	Bad, Challenging, Difficult, Selfish, Weak, Ungrateful, Stressful, Unpleasant, Irresponsible

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Table II Mean scores for demographic data

Demographic Variables								
Gender		Age	Education		Experience	Personal experience of drug or alcohol problems		
Male	Female		Below degree	Above degree		No		Yes
39	74	23-67 years (M=44)	31	79	7-35 months (M=11)	69		44

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Table III Significant differences in demographic variables

	Significant t-tests																	
	Gender						Education level						Personal experience of substance use					
	Male		Female				<degree		>degree				No		Yes			
	M	SD	M	SD	*t*	*d*	M	SD	M	SD	*t*	*d*	M	SD	M	SD	*t*	*d*
CF	-	-	-	-	-	-	42.81	8.88	48.92	10.79	2.36*	0.62	49.28	9.97	44.56	11.44	2.12*	0.49
Emotional Suppression	16.00	5.84	13.01	5.16	2.07*	0.41	-	-	-	-	-	-	-	-	-	-	-	-
Emotional Contagion	-	-	-	-	-	-	-	-	-	-	-	-	13.23	9.97	11.19	3.13	3.39**	0.68
Strain	3.32	.81	2.73	1.11	2.93**	0.52	-	-	-	-	-	-	-	-	-	-	-	-
Quantitative Demands	4.62	1.68	3.73	1.08	2.48**	0.51	-	-	-	-	-	-	-	-	-	-	-	-
Emotional Demands	-	-	-	-	-	-	4.55	1.60	5.83	1.31	-3.47***	0.70	-	-	-	-	-	-
Predictability	-	-	-	-	-	-	4.94	2.09	3.92	1.65	2.66**	0.54	-	-	-	-	-	-

Notes: *p< .05, **p< .01, ***p< .001; M = Mean; d= effect size

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Table IV Experiences of negative events at work

	Number of participants	Source of negative event			
		Clients	Subordinate staff	Colleagues	Superiors
No Negative Events	30	-	-	-	-
Sexual Attention	25	19	2	2	7
Verbal Threat	53	52	1	2	-
Physical Threat	21	21	-	-	-
Bullying	37	4	3	19	15

Notes: Participants were able to check multiple experiences and sources

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Table V significant Pearson's correlations

	CF	CS	Strain	Intention to Leave	Emotional Suppression	Cognitive Reappraisal	Emotional Contagion	Negative Events	IAT
CF									
CS	-.659***								
Strain	.630***	-.591***							
Intention to Leave	.269**	-.297**	.293**						
Emotional Suppression	.429***	-.331**	.199*	-					
Cognitive Reappraisal	-.372***	.426***	-.274**	-	-				
Emotional Contagion	.387***	-.294**	.224*	-	-	-.355***			
Negative Events	.327***	.-211*	-	-	.192*	-	-		
IAT	-	-	-	-.281**	-	-	-	-	

*Notes: *p< .05, **p< .01, ***p< .001*

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Table VI COPSOQ II Pearson's coefficient correlations

	Quantitative Demands	Tempo	Emotional Demands	Decision Authority	Development	Meaning	Commitment	Predictability	Rewards	Role Clarity	Quality Leadership	Social Support	Work/Family Conflict	Trust	Justice Respect	Health
Strain	.31**	-	.43***	-.38***	-.24*	-.37***	-.32**	-.43**	-.39***	-.48***	-.27**	-	.51***	-.41**	-.31**	-.39**
CS	-.40***	-.05*	-	.43***	.46***	.73***	.67***	.56***	.58***	.46***	.36***	.28*	-.39***	.51***	.49***	.37***
CF	.23*	-	-	-.38***	-.34**	-.54***	-.33**	-.48***	-.45***	-.36***	-	-	.64***	-.28**	-.29**	-.49***
Emo sup	.20*	-	-	-.25**		-.30**	-.21*	-.23*	-.20*	-	-	-	-	.28**	-.21	-.26**
Co reapp	-	-	-	.22*	.40***	.40***	.33**	.26**	.38***	.24*	.19*	-	-		.33**	.29**
Emo conta	-	-	-	-	-.27**	-.27**	-	-.26**	-.32**	-	-	-	-	-	-.24*	-.23*

*Notes: *p< .05, **p< .01, ***p< .001; - not significant; Emo sup= emotional suppression, Co reap= cognitive reappraisal, Emo conta= emotional contagion*

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Figure II Emotional suppression and emotion contagion as moderators of strain and CF

$\Delta R2 = .025$, F(1, 80)= 5.40, p= .023

$\Delta R2 = .026$, F (1, 80) = 5.52, p= .021

Emotion contagion

Emotional suppression

Workplace Strain

CF
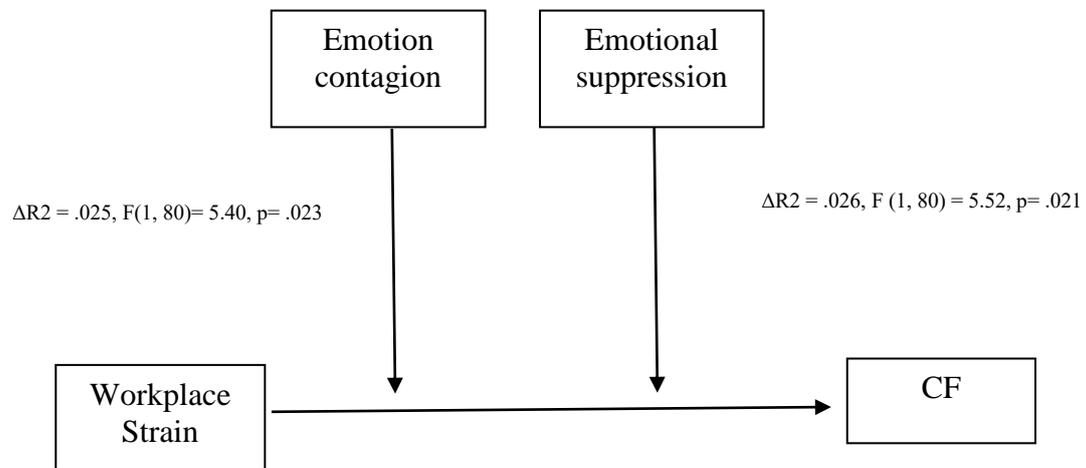
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Figure III Conditional effects of emotional suppression and emotion contagion as a
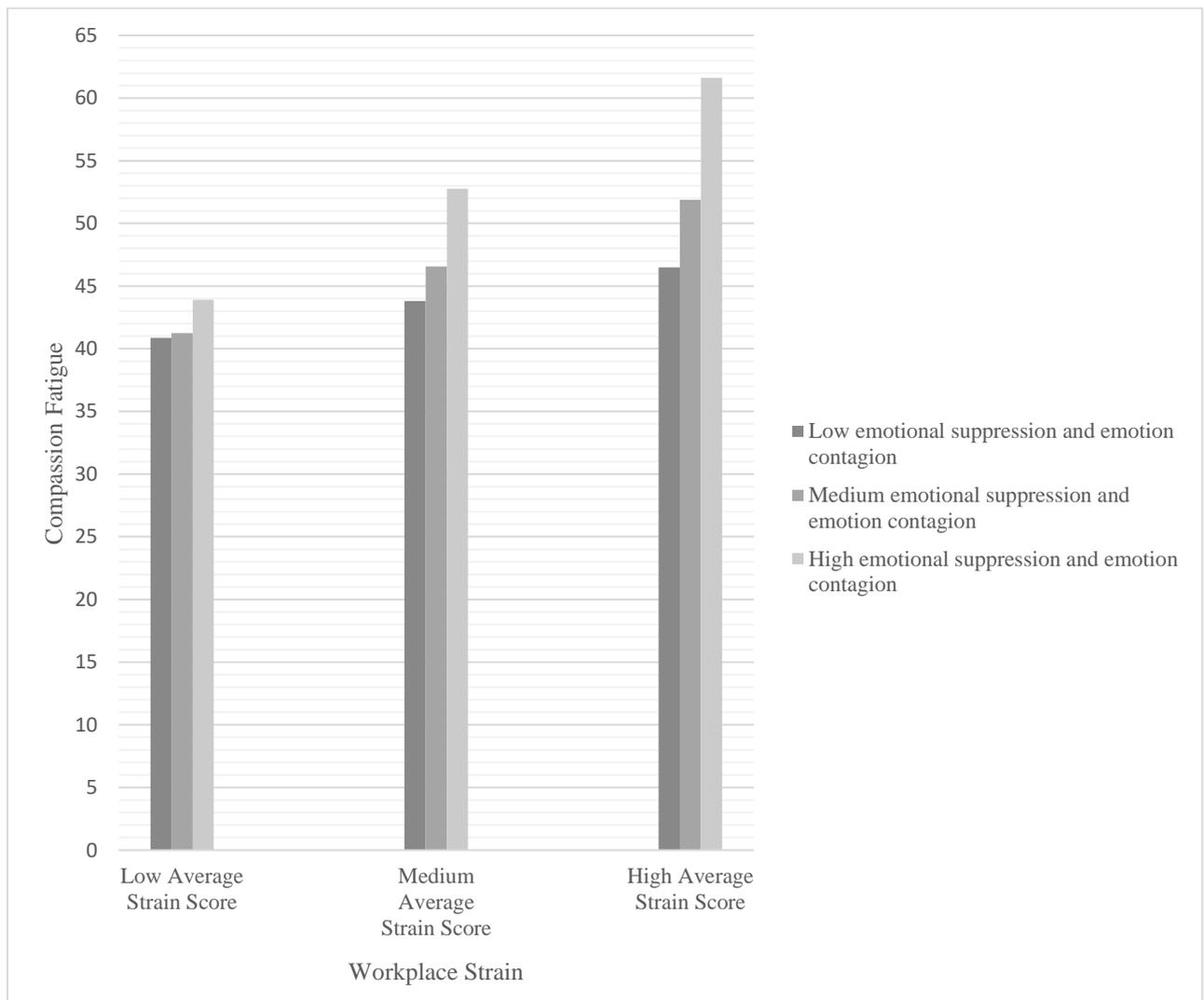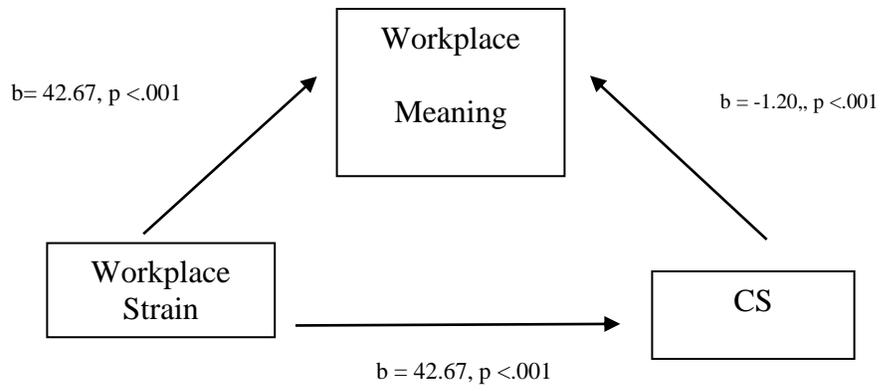
moderator of low, medium, and high scores of strain on CF

Figure IV Mediation of meaning on strain and CS

b= 42.67, p <.001

Workplace Meaning

b = -1.20,, p <.001

Workplace Strain

CS

b = 42.67, p <.001

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Appendices

Appendix A IAT Example Trials

Below is a pictorial example of an IAT trial in which target concepts (substance use and obesity) are paired with evaluations (compassion and non-compassionate words). Participants are required to categorise the word in the centre of the screen according to the target concepts and to correct any errors before proceeding. For example, in trial 1 the word "hopeful" is correctly categorised with "Drug and Alcohol use or Positive", in trial 2 this is reversed.

Trial 1

Drug and Alcohol Use Or Positive **Obesity Or Negative** **Hopeful** Press E or I to advance to the next word/image. Correct mistakes by pressing the other key.	**Drug and Alcohol Use Or Positive** **Obesity Or Negative** **Challenging** Press E or I to advance to the next word/image. Correct mistakes by pressing the other key.

Trail 2 (reverse trail)

Drug and Alcohol Use Or Negative **Obesity Or Positive** **Hopeful** Press E or I to advance to the next word/image. Correct mistakes by pressing the other key.	**Drug and Alcohol Use Or Negative** **Obesity Or Positive** **Challenging** Press E or I to advance to the next word/image. Correct mistakes by pressing the other key.

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Appendix B Further Analysis

Table VII shows the multiple regression analysis for strain and emotional factors. For CF, perceived strain of working with substance use, emotional suppression and emotional contagion explained 58% of the variance. For CS, strain and emotional suppression explained 44% of the variance.

Table VII multiple regression of strain and emotion factors

Variables	Compassion Fatigue			Compassion Satisfaction		
	B	Std. Error	Beta	B	Std. Error	Beta
Working with drug/alcohol users really puts strain on me.	4.955	.764	.493***	-2.572	.463	-.474***
Cognitive Reappraisal	-.100	.153	-.053	.155	.093	.151
Emotional Suppression	.682	.148	.346***	-.243	.088	-.228**
Emotion Contagion	.885	.277	.252**	-.186	.164	-.101
R^2	.58			.44		
F	27.69***			17.11***		

*Notes: *p< .05; **p< .01; *** < .001*

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Appendix C Notes for authors

The International Journal of Drug Policy provides a forum for the dissemination of current research, reviews, debate, and critical analysis on drug use and drug policy in a global context. It seeks to publish material on the social, political, legal, and health contexts of psychoactive substance use, both licit and illicit. The journal is particularly concerned to explore the effects of drug policy and practice on drug-using behaviour and its health and social consequences. It is the policy of the journal to represent a wide range of material on drug-related matters from around the world. The International Journal of Drug Policy is ranked 3rd out of 34 journals in the substance useBSTANCE ABUSE category in the 2016 Journal Citation Report, and has an Impact Factor of 3.479. 2016 Journal Citation Report Clarivate Analytics, 2017.

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Chapter 3 Critical appraisal

Critical reflections on professionals' experiences of distress, wellbeing, and self-care

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Doctorate in Clinical Psychology

Lancaster University

Word Count: 3,712

CRITICAL APPRAISAL

Introduction

This thesis comprises a qualitative literature review and a quantitative empirical study; both focusing on understanding Compassion Fatigue (CF). CF is a term that originated from research with trauma therapy, and describes the reduction in the capacity to respond compassionately as a consequence of repeated or prolonged exposure to another's distress (Figley, 1995). The systematic meta-ethnography reviewed eleven papers to understand the lived experience of mental health professionals and CF, secondary trauma (sometimes referred to as vicarious trauma), and burnout. Three broad themes emerged: understanding the experiences; causes and contributions; and surviving and thriving. When professionals described their experiences, the concepts of CF, secondary trauma, and burnout frequently overlapped, suggesting that these concepts need to be explored further. The review also highlighted that despite having an understanding of the impact of working with distress and the effects of CF, mental health professionals were not always able to maintain their own well-being and partake in self-care. This emphasized the influence of wider systems and the need for systemic intervention focusing on attitudes and organisational cultures.

Subsequent to the literature review, an e-survey on CF, emotional regulation, and workplace factors identified 57% of substance misuse services (SMS) professionals were at risk of CF, yet 81% experienced Compassion Satisfaction (CS). The relationship between CF and the perceived strain of working with substance use was influenced by professionals' emotional skill. CS linked with being able derive meaning from their work. Similar to the literature review, the need for intervention at a system level aimed at creating change in the emotional climate of services was highlighted. At an individual level, training and supervision that supports self-reflection may help professionals to increase their awareness of how their own emotional skills

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and work attitudes may interact with the service in which they work, and the population they work with.

The current literature review and research highlighted the conceptual issues around describing professionals' experiences of working with distress. Using both qualitative and quantitative methods was key in being able to critically approach CF as a concept and identify the gaps between theory and lived experience. However, because of the conventional standards for publication, there was limited opportunity to reflect on this within each of the sections. As such, this critical appraisal will focus on reflection around the concept of CF, and its utility for describing professionals' experiences. In doing so, the author will also reflect on their own experiences of working with distress, and how this fits with the current conceptualization of CF.

Is there a common experience of workplace distress?

The aim of the current empirical paper was to add to the existing literature. Therefore, the concept of CF and the ProQOL (Stamm, 2010) was central to the design of the study. This has revealed some strong evidence of CF in SMS and could support SMS and individuals to think about self-care and wellbeing in the workplace. The term CF has been applied and explored across a multitude of health care professions (Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski, & Smith-MacDonald, 2017). The concept of CF has raised awareness and provided a platform from which healthcare providers' experiences of working with distress can be explored. However, the complexity of compassion, individual experiences of stress and distress, and what constitutes wellbeing, raises questions as to whether professionals' experiences can be described by a singular (or three overlapping) terms. It is possible that these experiences are so diverse that a single term is not applicable and a more flexible approach to understanding distress is necessary (Sinclair et al., 2017). Sinclair et al., (2017) highlighted this

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using an example of a therapist working with trauma in comparison to a nurse working in

palliative care, suggesting that the types of distress these professionals are exposed to may be

fundamentally different and therefore the associated response may also be different.

Furthermore, given the different proximity to others' distress, and varying levels of responsibility

for that distress, it is likely that professionals working within the same service may respond

differently to others' distress. For example, a lead clinician responsible for making care decisions

may be exposed to different stressors than a support worker who is exposed to an individual's

day to day distress. In a meta-synthesis of the concept of CF, Sinclair et al. (2017) suggested that

it is unlikely that the concept of CF is generalizable across healthcare settings.

However, many psychological concepts, theories, and research rely on identifying the

commonalities across different individual experiences, and thus face a similar dilemma described

by Sinclair et al. (2017). In completing a literature review of CF, secondary trauma, and burnout,

inclusive of different settings/professions within mental health, common themes emerged. The

existence of distress in response to working in mental health settings was apparent, and for some

this was linked to witnessing others' difficult experiences. However, for many mental health

professionals much of the distress originated from the lack of resources, such as peer support and

supervision, the increasing demands in case complexity, and diversification of the roles and

responsibilities in their jobs. Goetz, Keltner, & Simon-Thomas (2010) suggested that the ability

to be compassionate relies on professionals' appraisal that they have the physical and/or

psychological resources to cope. Similarly, theories on stress highlight the importance of

resources and suggest that in times of stress individuals may try to conserve their resources

(Halbesleben, Neveu, Paustian-Underdahl, & Westman, 2014). Reflecting this, the importance of

resources was highlighted in the research findings that workplace factors were associated with

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CF. It is therefore possible that the common factor across mental health professions is the

perceived lack of resources and support. Valent (2002) argues in perceiving a lack of resources,

healthcare professionals are likely to feel underprepared and overwhelmed, and therefore become

emotionally exhausted.

The impact of resources is important to consider within the changing context of

healthcare systems which are under pressure to "offer more for less" (Charter for Compassion,

n.d). A lack of compassionate care along with staff burnout in the National Health Service

(NHS) have been highlighted by the media. In the NHS there is increasing emphasis on

evidence-based and target driven care, such as length of stay, and clinical and economic

outcomes (Flynn & Mercer, 2013). It is argued that the experience of care and compassion, and

subsequently the quality of care, are at risk of being lost amongst more easily quantifiable targets

and outcome measures (Charter for Compassion, n.d). Target driven care may also prioritise

short term outcomes, which has the potential to create further future burden on the healthcare

system due to 'incomplete' treatment. Therefore, with increasing emphasis on efficiency,

competition between NHS trusts, and privatization, the NHS runs the risk of becoming output

focused at the cost of compassion, and compromising professionals' values and wellbeing (Flynn

& Mercer, 2013).

Is it possible to measure Compassion Fatigue?

Definitions of compassion are complex and vary across the literature. However, in the

context of healthcare, compassion has been broadly understood as the relational connection built

upon a combination of empathy (understanding another's perspective and connecting with their

emotional experience), willingness to engage in others' distress with a genuine and felt

response; and the desire to alleviate that distress (Hojat, 2007). There is considerable evidence

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to suggest that the act of caring for others and showing compassion to others can contribute to difficult emotional and relational experiences and reduce professionals' ability to engage with others (Turgoose & Maddox, 2017). However, it is questionable whether this is directly connected with professionals' basic capacity to be compassionate. In Stamm's (2010) conceptual model of CF, secondary trauma and burnout combine with a lack of CS to contribute to the development of CF. This model informed the development of the three sub-scales in the Professional Quality of Life scale (ProQOL, Stamm, 2010). However, the components of compassion, including whether individuals seek to understand and act on the behalf of others to relieve their distress, are not directly addressed in the ProQOL (Sinclair et al., 2017). It could therefore be argued that the majority of the literature on CF using the ProQOL sample professionals' responses to their work, without tapping directly into their capacity to provide compassionate care.

It has been well established that research participants frequently present a positive representation of themselves through socially desirable responding (Van de Mortel, 2008). It is recognized that this has the potential to limit the validity of research results based on self-report methods by generating false relationships between variables (Van de Mortel, 2008). Much of the current research on CF uses self-report measures (Turgoose & Maddox, 2017; Newell & MacNeil, 2010). Given that compassion is a positive attribute, amongst caring professions it is likely to be a socially desirable trait. Beyond a desirable trait, compassionate care has been described is as an essential moral choice that goes beyond simply responding to distress (Von Dietze, & Orb, 2000). Questions have been raised as to whether compassion is an innate trait in healthcare professionals, and it has been suggested that compassion can be fostered but not taught (Sinclair et al., 2016). Therefore, it is possible that professionals are unwilling or unable

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to self-report CF, and that experiencing, reflecting on, or admitting to CF may undermine professionals' confidence in their skills and moral values around caring.

The influence of social desirability as a limiting factor in CF research has been acknowledged in some studies (Galek, Flannelly, Greene, & Kudler, 2011; Sprang, Craig, & Clark, 2011). It is possible that the focus on resources, arguably a way of externalizing the distress or negative feelings professionals have towards the people they work with, could reflect professionals (in)ability to recognize or admit loss of compassion. Sheppard (2015) suggested that the term CF may be perceived as stigmatizing, in that it suggests that professionals are unable to cope with distress (the very thing which they were employed to do).

It is also possible that professionals' perception of compassion and their displays of compassion are different from the experiences of those who are being cared for. For example, professionals may perceive themselves as acting compassionately, but this may not be the felt experience of service users. One study identified that only 53% of 800 patients surveyed felt that they received compassionate care (Lown, Rosen, & Martilla, 2011). It would therefore be interesting to research services users' perspectives of the compassionate care they have received, and whether they feel that professionals might have been compassionately fatigued. Research should also consider using observational and behavioural methods to evaluate compassionate care.

A qualitative study of patients' perspectives of compassion in nursing highlighted the importance of professionals investing time to engage with the whole person, beyond the issue for which they are seeking help (Bramley & Matiti, 2014). That is, for care to feel compassionate, professionals should be prepared to engage with the individual in their context (Bramley & Matiti, 2014). It is likely that the felt sense of compassion extends beyond professionals'

alignment as health, social, or mental health providers, which may require more resources from professionals, and for a person to feel truly compassionately cared for, it may be necessary to attend to the individual at a physical, psychological, and social level.

These principles are embedded in the biopsychosocial model which, at least in theory, informs many mental health services. The underpinning principles of this model is to understand suffering at multiple levels, from societal to individual biology by engaging with an individual's subjective experiences (Borrell-Carrió, Suchman, & Epstein, 2004). Despite having models and principles that support compassionate care, in completing the current thesis it was felt as though there was a lag in the felt sense of compassion. It is possible that this can be explained by a psychological disconnection between the 'head and the heart' (Barnard & Teasdale, 2014). That is, professionals may go through the motions of compassion without engaging in the felt sense of compassion or the 'heart'. It is possible that to understand CF, research needs to move away from theoretical explanations and models towards a more relational understanding of professionals lived experience of their own and others' distress. This may be further compounded by increasing demands and service structures (such as having a set number of sessions and the move towards telephone therapy), which reduces the amount of face to face contact professionals have with service users (Killian, 2008; Sim et al., 2016). This reduction in contact and time pressure may lead to a narrower focus on solving the problem in a timely manner at the cost of person centered compassionate care.

Alternatives to Compassion Fatigue

In one paper, a nurse described CF as "an intense and devastating feeling, but I won't call it a loss of compassion" and that they were "a compassionate person who just doesn't feel anymore" (Sheppard, 2015 p.58). Nurses did not identify with the loss of compassion, instead

they described themselves as deeply compassionate yet that they were affected by "unfairness" and felt emotionally overwhelmed (Sheppard, 2015). Many professionals enter into their caring roles with tendencies towards compassion and empathy, and the intention of helping others (Figley, 2002). Although many professionals do leave their caring roles, many also remain. The Health Foundation estimated that within NHS England from 2012 to 2015, staff monthly turnover ranged between 0.6% and 1.7% of total staff (The Health Foundation, 2017). It was also reported that an increasing number of professionals were joining the NHS, and that this exceeded the number of professionals leaving (The Health Foundation, 2017). If the consequences of caring for others is the loss of compassion, would so many professionals remain in post and continue to suffer the distress of others?

In the current literature review, individuals identified both positive and negative aspects of their role and suggested that despite the negative impacts they maintained some level of compassion and desire to help. For example, some described the need to withdraw from their service users (Hernández, Engstrom & Gangsei, 2010), yet mental health professionals experienced "a helpless rage" in their inability to support service users (Sui & Padamanabhanunni, 2016, pp. 130). Some mental health professionals expressed frustrations on behalf of their service users (Hernández et al., 2010), suggesting they felt the need to stand up for others. Strong emotional responses such as "rage" and frustration suggested that they were still deeply and compassionately engaged with their service users' distress. In the current research paper, both CF and CS were evident amongst SMS professionals. It is acknowledged that CF and CS are conceptually different (Stamm, 2010), yet it was surprising that SMS professionals were both fatigued and satisfied with their roles at the same time. The duality of these experiences further highlights that more exploration and clarification of the concepts is necessary.

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  Given the lack of conceptual clarity around CF, some papers have suggested alternative explanations. In a critical paper, Kanter (2007) argued that research on CF has neglected the psychodynamic underpinning of the relationship between service users and professionals. The author suggested that applying the term CF to a distressed professional is "akin to applying the diagnosis of ''fatigue'' to a medically ill patient" (p. 291), and that the term had little value other than identifying that an individual was experiencing stress (Kanter, 2007). Instead Kanter (2007) argued that CF is better understood as countertransference, the inevitable and meaningful dynamic between professionals and service users', which includes fantasies, thoughts, attitudes, affects and behavioral enactments, and may include important past relationships of the professional.

  The concepts of countertransference and CF are difficult to distinguish, with original literature on CF describing examples and case studies (Figley, 2002) which could also be conceptualized as countertransference (Berzoff & Kita, 2010). However, Berzoff & Kita (2010) suggest that CF and countertransference are distinct, and that the distinction is best understood in regards to the necessary intervention. A professional experiencing countertransference would benefit from supervision and reflection (Berzoff & Kita, 2010). Alternatively, an individual who experiences CF should benefit from self-care (Berzoff & Kita, 2010). CF is unique in that it develops overtime in the context of others' distress, while countertransference can occur immediately and as a virtue of the therapeutic interaction regardless of distress (Berzoff & Kita, 2010). CF is not an essential or helpful consequence of therapeutic work and can compromise professional values of caring (Berzoff & Kita, 2010). However, countertransference is a meaningful, often helpful, and sometimes essential part of therapeutic work. At the time, countertransference can be challenging for professionals, but not always. The experience of

countertransference fosters the possibility of reflection and change in both the service user and the therapist (Berzoff & Kita, 2010), whilst CF may reduce reflection.

It is likely that both CF and countertransference are key to understanding professionals' experiences. Berzoff & Kita (2010) suggest that countertransference is present within all experiences of CF. In the current literature review, for mental health professionals who maintained CS, there was evidence that professionals saw their interactions with services users as a positive challenge which broadened their thinking, encouraged reflection, and fostered personal growth (Ling et al., 2014). It is possible that these experiences are more related to countertransference, and that being aware of countertransference and being supported to reflect on it, is linked with greater feelings of satisfaction. It is possible that countertransference and CF sit on a similar continuum to CS and CF. That is, when professionals are within their window of resources, difficult or challenging experiences with services users may be seen as, and engaged with as, countertransference. However, when professionals are low on resources (and are therefore more likely to want to conserve their resources (Hobfoll, 1989), they may be less able to engage in the reflective process of countertransference, and thus these experiences may develop into distress.

The importance of interacting with systems and context

In developing my skills in reflection, and through the process of completing this thesis, I have become more aware of the impact that working with others' distress has on me. This awareness has brought to my attention the importance of my own self-care. In doing so, I have noticed how this conflicts with the culture in which Clinical Psychologists and mental health professionals work. To compassionately care for someone is to prioritize their needs, something which becomes more important the greater the distress and risk. However, it is also in these

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times when self-care is important. Observing others, there is an ethic of selflessness and this

fundamental conflict seems to have made self-care a novelty, something that we know should be

a healthy option, recommend to each other and then continue not to practice. Research suggests

that beliefs about self-care being helpful, and the time spent doing these activities were not

associated (Bober & Regehr, 2006). Given the increasing pressures to "do more with less" in

care settings (Charter for Compassion, n.d), the gap between beliefs and self-care behavior is

likely to increase (Killian, 2008).

Some studies have found little evidence that self-care and leisure time reduced stress or

CF (Killian, 2008; Bober and Regehr, 2006). It was concluded that focusing solely on individual

strategies may not be sufficient to change professionals' experiences (Killian, 2008). Killian

(2008) suggested that focusing on individual interventions may encourage attitudes of blame,

suggesting that professionals are not able to manage their individual responses, self-care, or

make use of supervision. In the current literature review, many participants demonstrated

knowledge of CF and the importance of self-care, yet were unable to put this into practice and

act proactively. Having less time, increasing demands (Ohrt & Cunningham, 2012) and poor

work-place relationships (Sim, Zanardelli, Loughran, Mannarino, & Hill, 2016) may create

environments where identifying and acting on CF could be challenging. The systematic review

findings suggest that awareness at an individual level is not sufficient, and a more systemic

approach is necessary. Killian (2008) proposes that there is a need for a "paradigmatic shift in

our understanding of therapists and professional selfcare, where we look at professionals' stress

and coping in structural, political, and organisational contexts" (p. 42). It is possible that the

conceptual difficulties surrounding CF as a concept are due to placing too much emphasis on the

individual and their experiences. This suggests that the individual is the problem, and distracts

from the wider organisational issues within healthcare systems. Perhaps the concept of CF is better applied to the system rather than the individual. Therefore, it is a service which can become compassionately fatigued and any intervention should be aimed at changing the system.

Having experienced a number of different placements during training, I have noticed that the distress felt by professionals and collective teams frequently reflected the challenges faced by the people that they were working with. For example, in Learning Disability Services, professionals' feelings mirrored service users' experience of social injustice with their own relationships with the service and the wider system. That is, professionals' working with trauma may be more likely to experience or re-experience trauma/distress, whilst professionals working with individuals experiencing injustice or social deprivation, may also experience unfairness and frustration in the workplace. From this perspective, it is important that research on professional wellbeing needs to take full account of the context in which professionals are working.

Final reflections

Both the literature review and research paper highlighted that professionals' experiences of distress and wellbeing are complex and difficult to capture in a single term. Professionals' experiences and perceptions of the impact of their jobs are intrinsically linked to the context in which they work, along with the relationship with their service users, the environment, and team. Whilst professionals must hold some responsibility for their own wellbeing, CF needs to be addressed at an organisational and cultural level. Focusing on developing and maintaining compassionate services may be a more clinically beneficial intervention than alleviating CF at an individual level. Further research should focus on understanding which factors foster and maintain compassionate systems.

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This thesis has brought my own experiences and wellbeing to the forefront of my clinical practice, and it has challenged my ideas and priorities in the workplace. Clinical Psychology, as a profession, is uniquely placed within multidisciplinary teams to support positive emotional climates and promote attitudes that allow services to operate compassionately. Beyond this, Clinical Psychologists have the opportunity to highlight the importance of wellbeing at an organisational level within service cultures from the point of commissioning through to delivery and evaluation.

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Chapter 4 Ethics

Ellysia-Grace Thompson

Doctorate in Clinical Psychology

Lancaster University

Word Count: 4,708 (FHMEC application and protocol)

ETHICS

Health & Medicine | Lancaster University

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

Application for Ethical Approval for Research

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Title of Project: What Contributes to Compassion Fatigue in Health Professionals Working in Drug and Alcohol Services

Name of applicant/researcher: Ellysia-Grace Thompson

ACP ID number (if applicable)*:   **Funding source (if applicable)**

Grant code (if applicable):

*If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].

Type of study

Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

☒ Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM   Doctorate in Clinincal Psychology

2. Contact information for applicant:
E-mail: : e.thompson4@lancaster.ac.uk   **Telephone:** 07940902828 (please give a number on
which you can be contacted at short notice)

Address: Clinical Psychology, Faculty of Health and Medicine, Furness Building, Lancaster University, Lancaster, LA1 4YG

3. Names and appointments of all members of the research team (including degree where applicable)

Principle Researcher Ellysia-Grace Thompson, Trainee Clinical Psychologists.
Research Supervisor Dr Ian Fletcher (Supervisor, Senior Lecturer at Lancaster University).
Field Supervisor Dr Adam Huxley (Clinical Psychologist, Change Grow Live).
Field Supervisor Dr Martin Seager (Clinical Psychologist, Change Grow Live)

ETHICS

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3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the <u>FHMREC website</u>

PG Diploma ☐   Masters by research ☐   PhD Thesis ☐   PhD Pall. Care ☐

PhD Pub. Health ☐   PhD Org. Health & Well Being ☐   PhD Mental Health ☐   MD ☐

DClinPsy SRP ☐   [if SRP Service Evaluation, please also indicate here: ☐]   DClinPsy Thesis ☒

4. Project supervisor(s), if different from applicant: Research Supervisor Dr Ian Fletcher (Supervisor, Senior Lecturer at Lancaster University), Field Supervisor Dr Adam Huxley (Clinical Psychologist, ████████████ Live), Field Supervisor Dr Martin Seager (Clinical Psychologist, ████████████)

5. Appointment held by supervisor(s) and institution(s) where based (if applicable): Principle Researcher Ellysia-Grace Thompson, Trainee Clinical Psychologists, Research Supervisor Dr Ian Fletcher (Supervisor, Senior Lecturer at Lancaster University), Field Supervisor Dr Adam Huxley (Clinical Psychologist, ████████████), Field Supervisor Dr Martin Seager (Clinical Psychologist, ████████████)

SECTION TWO
Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants

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1. Anticipated project dates (month and year)
Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

Data Management
For additional guidance on data management, please go to <u>Research Data Management</u> *webpage, or email the RDM support email:* <u>rdm@lancaster.ac.uk</u>
3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chat-rooms' no
4c. If yes, where relevant has permission / agreement been secured from the website moderator? no
4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users? no

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with the Data Protection Act 1998.

6a. Is the secondary data you will be using in the public domain? no
6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

8. Confidentiality and Anonymity
a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?
yes
b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE
Complete this section if your project includes *direct* involvement by human subjects

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

Compassion fatigue is a descriptive term for the negative psychological impacts of helping others and includes burn out and secondary trauma (Stamm 2012). Being exposed to people's experiences of drug use and the associated adversity can be highly emotive, and drug and alcohol workers may be at risk of developing compassion fatigue (Fahy, 2007), which could impact on their ability to provide care (Lawson, 2007).

This study seeks to apply what is already known about the causal factors of compassion fatigue to professionals working in drug and alcohol services. Adapting existing questionnaires and measures to create an online survey, this study will investigate what contributes to compassion fatigue including, individual and emotional characteristics of staff, the influence of the organisation/service, and characteristics of the people they are working with. The results of this study will improve understanding of what causes compassion fatigue in drug and alcohol workers.

2. **Anticipated project dates (month and year only)**

Start date: May 2017   End date: September 2018

Data Collection and Management
For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

Participants will be any professional working within drug and alcohol services, including paid and unpaid staff, with a minimum of three months experience of direct contact with drug and alcohol users. Drug and alcohol services frequently employ voluntary or honorary, staff some of whom have previous or current experiences of drug and alcohol problems. To be inclusive, and to collect a representative sample of people working for drug and alcohol services, this project will include people working on both paid and unpaid contracts. As such, it is possible that in doing this, people who are still accessing drug and alcohol services may take part in the survey (although we will not specifically recruit this sample). It will be made clear on all information provided to participants that the purpose of the survey is to investigate compassion fatigue from their professional perspective.

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The project hopes to recruit a minimum sample of 108 participants. All participants will be aged 18 or above. There will be no restrictions on gender. All panel members will be English speaking. The research will be conducted internationally, facilitated by the online nature of the study.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

Participants will be recruited through professional contacts of the research team, contacting relevant services directly (for example, ██), and by advertising with non-NHS professional drug and alcohol networks and special interest social media groups (such as Facebook, Twitter and discussion forums). Through the aforementioned networks and contacts, potential participants will receive participant information and provided with email contact details of the research team if they wish to participate. On contacting the research team participants will be asked to provide information of their professional designation and their professional experience of working with drug and alcohol users, in order to ascertain if they would be a suitable participant.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

Power analysis guidelines suggests that for a medium effect size, an alpha significance level of 0.05 and power of
.08 and eight independent variables (described below), a minimum sample size of 108 is required (Miles & Shelvin, 2001).

An online e-survey design will be used to present existing quantitative measures to survey two dependant variables and eight independent variables. The variables and decision to use each of these measures was informed by the existing literature on compassion fatigue, vicarious trauma, and burnout with mental health and health workers.

The first dependant variable will be Compassion Fatigue and Compassion Satisfaction and will be sampled using the The Professional Quality of Life (ProQOL)–Revision IV Questionnaire (Stamm, 2009). The second dependant variable will be intension to stay in post/with the service and will be measured using questions described by Von Hipple (2008), "During the next year, I will probably look for a new job in another area" rated on a 5 point Likert scale.

Several independent variables will be sampled. Participants will be asked for demographic information (age, gender, length of time working in drug and alcohol services, professional alignment/level of education/training, and case load). Participants will also be asked to indicate whether they have had any personal experience of drug and/or alcohol problems using yes or no answers (participants will not be asked to provide further details). To measure staff's level of emotional coping the Emotional Regulation Questionnaire (Gross, & John, 2003) will be included. Emotional Contagion Scale (Siebert, Siebert, & Taylor-McLaughlin, 2007) and the Copenhagen Psychosocial Questionnaire II Short Questionnaire (Kristensen, Hannerz, Høgh, & Borg, 2005) will measure the influence of psychosocial work environment on compassion fatigue.

Finally, an Implicit Association Test (IAT Greenwald, McGhee, & Schwartz, 1998) will be used to measure staff's implicit attitudes towards drug and alcohol users. An IAT measures the strength of associations between concepts and positive and negative evaluations (Greenwald, McGhee, & Schwartz, 1998). In the current study, descriptive terms for drug and alcohol use will be compared with descriptive terms for obesity with compassionate and non-compassionate terms as evaluations. Obesity was chosen as a comparison group as research suggest both are highly stigmatized health conditions which people perceive as being a result of the individual's life choices and under their personal control (Budd, Mariotti, Graff, & Falkenstein, 2011; Van Boekel, Brouwers, Van Weeghel, & Garretsen, 2013). Furthermore, like problematic drug and alcohol use, obesity has both psychological and physical aetiology.

Research using IAT methodology, has identified that health care professionals and specialists working with obesity show an implicit bias towards people they work with (Budd et al., 2011). Professionals with more direct contact and reporting positive experience with people with obesity show less implicit bias than those with less direct contact (Budd et al., 2011). It is hypothesized that a similar relationship might be identified with drug and alcohol professionals. The following link provides further information on implicit association test https://iatgen.wordpress.com/.

Data will be collected and stored anonymously. To examine the relationship between the variables, correlations will be established and a regression analysis will be carried out. Variables which are significant will be entered into a multiple regression to establish which independent variables best predict compassion fatigue and intention to stay in post.

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with the Data Protection Act 1998.
Whilst the e-survey is live participant data will be stored electronically delivered via Qualtrics survey software and hosted by Lancaster University. At this point the data will only be available to the research team via email log in and password. When all data has been collected this raw data will be downloaded formatted into an excel file and stored on Ellysia-Grace Thompson's personal password protected folder on the Lancaster University H drive computer network, and no data will be downloaded onto personal PCs or laptops, data will be accessed and analysed via the virtual private network (VPN) facility. Formatted Data will be accessible to all members of the research team.

7. Will audio or video recording take place?   ☒ no ☐   audio ☐   video
a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder
8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE? Once the research project has been completed the data will be transferred to the Lancaster University server and following Ellysia-Grace Thompson's departure as a student, data will be maintained by Dr Ian Fletcher (supervisor). The data collected will be retained for 10 years as standard

8b. Are there any restrictions on sharing your data? No.

9.Consent
a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? yes

b. Detail the procedure you will use for obtaining consent?
Participants will be presented with participant information in an online format prior to indicating consent. Informed consent will be obtained online via a list of statements that outline what the study entails, the use of their data, and how data will be stored. Participants will be made aware that by continuing with the online survey there are giving consent for their data to be used for the purposes outlined. Participants will be made aware that the data will anonymised at point of collection. Participants will not be able to withdraw from the study as their data will be

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anonymised at the point of collection. Participants will be provided with contact details of the research team by which they can make any enquires regarding consent.

10.What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

The study asks participants to answer questions about their experiences of working with drug and alcohol users and compassion fatigue. It is possible that this may result in participants reflecting on their own coping strategies and levels of work related stress. At the end of the study, participants will be debriefed and given information of how to contact the research team should they have any questions. The participant information and debrief will contain information about sources of support, should participants feel distressed. This will include contact details for Samaritans' free confidential telephone line. Participants accessing the study from outside of the UK will be advised they can go to the Befrienders Worldwide website for emotional support, where they can access information, resources and local telephone contact numbers. It has not been possible to identify any internationally accessible sources of impartial drug and alcohol support. However, for advice on drug and alcohol participants will be directed to a free confidential advice website FRANK. Typically direct support for drug and alcohol problems would be accessed through the GP and participants will be advised that for further support, they should speak with their GP or local mental health team.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

As the participants are professionals and data will be collected online it is expected that there will be minimal risk to the research team. All contact details provided will be official work email addresses and telephone numbers to ensure that all contact made with participants regarding the study is in a professional capacity.

12. 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.

Participants will not gain any direct benefits from this study.

13.Details of any incentives/payments (including out-of-pocket expenses) made to participants: There will be no incentives or payments made to participants

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes
b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.
Participants' information will be annomysed at the point of collection and stored anonymously. No identifiable information will be collected. Participants will be made aware that their information will be collected anonymously prior to commencing the study.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

The project has consulted with four professionals with experience of working within drug and alcohol services to discuss the rational for the project and drafts of the survey. A target service has also provided consultation on possible recruitment.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

The results of the research will be written up and submitted as a Doctorate in Clinical Psychology thesis and will also be presented to students and staff of the Doctorate in Clinical Psychology program at Lancaster University. Results may also be presented for peer reviewed publication in an academic journal.

17.What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

Drug and alcohol services frequently employ voluntary or honorary, staff some of whom have previous or current experiences of drug and alcohol problems. To be inclusive and to collect a representative sample of people working for drug and alcohol services, this project will include people working on both paid and unpaid contracts. As such, it is possible that in doing this, people who are still accessing drug and alcohol services may take part in the survey, although we will not specifically recruit this sample, this may emerge as an independent variable. It will be made clear on all information provided to participants that the purpose of the survey is to investigate compassion fatigue from their professional perspective. Participants will be informed how they can access support should they experience distress following participation including, contact information for Samaritans, Befrienders Worldwide, a source of drug and alcohol information and advised that they can contact their GP or local mental health team.

Applicant electronic signature: | Ellysia-Grace Thompson | | 24.04.17 |

Student applicants: please tick to confirm that you have discussed this application with your supervisor, and that they are happy for the application to proceed to ethical review ☒

Project Supervisor name (if applicable): | Dr Ian Fletcher | Date application discussed | 24.04.17 |

Submission Guidance

1. Submit your FHMREC application <u>by email</u> to Diane Hopkins (d.hopkins@lancaster.ac.uk) as two separate documents:

   i. **FHMREC application form.**
   Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu
   above then choosing *show markup>balloons>show all revisions in line.*

   ii. **Supporting materials.**
   Collate the following materials for your study, if relevant, into a single word document:

      a. Your full research proposal (background, literature review, methodology/methods, ethical considerations).
      b. Advertising materials (posters, e-mails)
      c. Letters/emails of invitation to participate
      d. Participant information sheets
      e. Consent forms
      f. Questionnaires, surveys, demographic sheets
      g. Interview schedules, interview question guides, focus group scripts
      h. Debriefing sheets, resource lists

Please note that you DO NOT need to submit pre-existing measures or handbooks which

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support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submission deadlines:

    i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to Diane Hopkins **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.

    ii. The following projects will normally be dealt with via chair's action, and may be submitted at any
        time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:

        a. existing documents/data only;
        b. the evaluation of an existing project with no direct contact with human participants;
        c. service evaluations.

3. **You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application**

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Research Protocol

What Contributes to compassion Fatigue in Health Professionals Working in Drug and Alcohol Services

Research team: Ellysia-Grace Thompson (Trainee Clinical Psychologist), Dr Ian Fletcher (Supervisor, Senior Lecturer at Lancaster University), Dr Adam Huxley (Clinical Psychologist, XXXX), Dr Martin Seager (Clinical Psychologist, XXXXX).

Background information

Demonstrating the prevalence of problematic substance use, the World Health Organisation (WHO) (2012), estimates that 1 in 40 adults use illicit drugs regularly. It was reported that in 2009, 4.5 million people worldwide were receiving treatment for problems related to drug use (WHO, 2012). From these statistics, it can be seen that problematic substance use is a worldwide issue. However, low service uptake (Gilchrist et al., 2014) and poor treatment retention rate created a major barrier for successful recovery outcomes (Palmer, Murphy, Piselli, & Ball, 2009). Research on drug and alcohol service uptake has identified that negative staff attitudes are a significant barrier for people accessing services (Gilchrist et al., 2014).

Qualities that make mental health professionals effective, such as empathy and compassion, can also result in negative personal and psychological impacts for staff (Thompson, Amatea, & Thompson, 2014). Compassion fatigue is a term that first emerged in the literature within the context of working with traumatised patients and describes the emotional and physical reduction in ability for professionals to respond compassionately (Figley, 1995). Stamm's (2012) model of professionals' quality of life describes compassion fatigue in the context of the opposite term, compassion satisfaction, where an individual feels their role as a helper makes a significant positive difference. Therefore, compassion fatigue is a descriptive term for when an individual feels their role no longer makes a difference, leading to negative psychological experiences including burn out and secondary trauma (Stamm, 2012). Repeated exposure to highly emotional and distressing experiences has been

found to have vicarious impacts including compassion fatigue and burnout in mental health workers (Lawson, Venart, Hazier, & Kottler, 2007). Research has also found that this has a direct impact on the quality of services professionals can deliver (Lawson, 2007).

In a reflective paper, it was suggested that the challenging needs of drug and alcohol users (including ambivalence around treatment engagement), low levels of supervision, workforce issues, and low levels of training create an emotionally demanding environment for health professionals, resulting in a susceptibility to compassion fatigue, trauma, and burnout in drug and alcohol workers (Fahy, 2007). Drug and alcohol workers have been found to have higher burnout rates than other health care professionals and this was associated with increased psychological problems (Oyefeso, Clancy, & Farmer, 2008). Ducharme et al., (2008) identified that high workload and autonomy predicted emotional exhaustion, whilst work place support was linked with lower emotional fatigue in drug and alcohol workers.

Applying the Acceptance and Commitment Therapy model in a study of 669 alcohol and drug workers in the United States, levels of mindfulness (the psychological practice of noticing/being in the here and now) and workers values were found to be correlated with burnout (Vilardaga et al., 2011). Research has also been conducted on secondary trauma in drug and alcohol workers, finding association between job satisfaction, and commitment influencing staff turn-over (Bride & Kintzle, 2011). Despite emerging research on burnout and secondary trauma, the broader concept of compassion fatigue in drug and alcohol workers has been under researched. As a precursor to staff burnout and secondary trauma (Stamm, 2012), research identifying and understanding compassion fatigue could provide guidance for preventative measures.

Research has identified several contributing factors to compassion fatigue in health care professionals. In a qualitative study, 20 professionals working with trauma were interviewed on compassion fatigue and highlighted the importance of recognising signs of

work stress and identified that the poor ability to recognise and manage emotions was a risk factor for compassion fatigue and burnout (Killian, 2008). In the same study, participants also identified that access to supervision and case load influenced levels of compassion fatigue (Killian, 2008). In a large scale study of 7,497 board-certified working physicians on empathy, Gleichgerrcht and Decety (2013) found that whilst experiencing negative emotions promoted empathy, professionals who have difficulty regulating negative emotions are most susceptible to compassion fatigue and job dissatisfaction. Sprang, Clark, and Whitt-Woosley (2007) surveyed a large sample of mental health professionals and found that gender was a significant predictor of compassion fatigue, with women more likely to experience fatigue than men. However, due to the high representation of females in health care professions, findings around gender have been inconsistent (Gleichgerrcht & Decety, 2013). Higher levels of specialist training and professional alignment, was also associated with levels of compassion fatigue (Sprang et al., 2007).

Applying the existing literature on emotional awareness and regulation, and work related factors, this research project will investigate the factors of compassion fatigue in drug and alcohol workers. Additionally, due to the challenging nature of working with drug and alcohol users (Fahy, 2007), implicit attitudes towards this population will be investigated as a predictor of compassion fatigue or satisfaction. In developing this understanding, this study will investigate potential factors that may influence compassion fatigue in drug and alcohol workers and inform the process that might influence health professionals' wellbeing.

Method

Participants

Participants will be any professional, including paid and unpaid staff, working within drug and alcohol services with a minimum of three months experience of direct contact with drug and alcohol users. Many drug and alcohol services have programs whereby service

user's progress through peer support and mentoring programs towards voluntary contracts.

Therefore, staff who are employed under voluntary or honorary contracts will also be included. There will be an age restriction of 18 and no restrictions on gender, however all panel members will be English speaking. The research will be conducted internationally, facilitated by the online nature of the study. The project hopes to recruit a minimum sample size of 108.

Sample Selection. Participant selection will be through professional contacts of the research team and through advertising (see Appendix A: Information Poster) contacting relevant services directly, and by advertising with non-NHS professional drug and alcohol networks and special interest social media groups (including Facebook, Twitter, and discussion forums). Potential participants will be provided with the participant information sheet which outlines the study's aims, participant requirements, and contact details of the research team. Potential participants will contact the research team if they wish to participate and will be asked to provide confirmation of their direct experience with drug and alcohol users.

Design

A quantitative survey design will be used to measure the level of compassion fatigue and the factors which contribute to it. Demographic information will be gathered. Pre-existing measures will be adapted to be presented online in a questionnaire format to sample compassion fatigue/satisfaction, intension to stay in post, emotion regulation skills, level of emotional contagion and psychosocial influences of work. The e-survey will measure responses using forced response and Likert-scales. An Implicit Association Test (IAT Greenwald, McGhee, & Schwartz, 1998) will also be included to measure participants' implicit attitudes using synonyms and descriptive terms for compassion, drug and alcohol use/users in comparison with obesity.

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Procedure

   Consent. Informed consent will be gained online (Appendix B). Prior to completing

the e- survey participants will be presented with an online participant information sheet

which includes information about the study, procedure, consent, and withdrawal from the

study. Informed consent will be gained by presenting participants with a consent page on

the e- survey, by continuing with the e-survey consent will be assumed, participants will be

informed of this. The consent page will include statements of what participants are

consenting to including: what they will be asked to do; what their data will be used for; and

how their data will be stored.

  E-survey. Following consent participants will be presented with instructions for the online

e- survey (Appendix C). Participants will be asked to give demographic information, including

age, gender, years working within drug and alcohol services, and caseload. To establish the

influence of personal experiences, participants will also be asked whether they have

experienced a drug/alcohol problem. Participants will then complete a questionnaire which

will comprise of several adapted measures (Appendix E) including: the Compassion

Satisfaction and Compassion Fatigue (ProQOL) Version 5 (Stamm, 2009); Emotional

regulation questionnaire (Gross, & John, 2003); Emotional contagion scale (Siebert, Siebert, &

Taylor-McLaughlin, 2007); The Copenhagen Psychosocial Questionnaire II short

questionnaire for assessment of the psychosocial work environment (Kristensen, Hannerz,

Høgh, & Borg, 2005); and questions around intension to retain occupation position adapted from Von Hippel (2008).

Following this, a standard IAT (Greenwald, McGhee, & Schwartz, 1998) will be used to measure staff's attitudes towards drug and alcohol users in comparison with obesity. Descriptive terms for drug and alcohol use will be compared with descriptive terms for obesity with words representing compassionate and non-compassion as evaluations (Appendix F). Completed online, the standard IAT protocol involves an initial trial where participants quickly categorize two concepts (e.g. drug and alcohol use and obesity) by pressing one of two keys. Following this, words representing positive and negative evaluation (compassion and non-compassion) are categorized. In the proceeding, trials all four categories are classified. Firstly with each assigned to the same key as in the initial two blocks and then response are keys reversed. Participants are required to correct errors they make, and the response times are measured. The difference or similarities in average latency between the concepts is measured to show participants implicit attitudes. The following link provides further information on implicit association and will be used to develop the IAT https://iatgen.wordpress.com/.

Finally, participants will be debriefed which will provide further information about the study, how they can contact the research team, and information about support they can access should they feel distressed following participation (Appendix G).

Proposed Analysis. Power analysis guidelines suggests that for a medium effect size, an alpha significance level of 0.05 and power of .08 and eight independent variables (described above), a minimum sample size of 108 is required (Miles & Shelvin, 2001). To examine the relationship between the variables, correlations will be established and a regression analysis will be carried out. Variables which are significant will be entered into a multiple regression to establish which independent variables best predict compassion fatigue and intention to stay in post.

Potential Practical Issues

Ethical Concerns

 Drug and alcohol services frequently employ voluntary or paid staff some of whom have previous or current experiences of drug and alcohol problems. To be inclusive, and to collect a representative sample of people working for drug and alcohol services, this project will include people working on both paid and unpaid contracts. As such, it is possible that in doing this, people who are still accessing drug and alcohol services may take part in the survey (although we will not specifically recruit this sample). It will be made clear on all information provided to participants that the purpose of the survey is to investigate compassion fatigue from their professional perspective.

Confidentiality

Participant information will be collected and stored anonymously. Only the research team will have access to raw data, which will be stored and transported in a secure manner on a password protected computer. Following analysis and write up data will stored on the university secure server for 10 years and following the departure of XXXXX as a student will be maintained by XXXXX.

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ETHICS

Ethical Approval Letter

Lancaster University

Applicant: Ellysia-Grace Thompson
Supervisor: Ian Fletcher
Department: Health Research
FHMREC Reference: FHMREC16141

14 August 2017

Dear Ellysia

Re: What Contributes to Compassion Fatigue in Health Professionals Working in Drug and Alcohol Services

Thank you for submitting your research ethics amendment 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 Committee, I can confirm that approval has been granted for the amendment to 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 at the email address below (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 me if you have any queries or require further information.

Tel:- 01542 592838
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

Dr Diane Hopkins
Research Integrity and Governance Officer, Secretary to FHMREC.

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Chapter 5 Appendices

Appendix A Participant Information

Participant Information
What Contributes to compassion Fatigue in Health Professionals Working in Drug and Alcohol Services

My name is Ellysia-Grace Thompson and I am conducting this research at Lancaster University, Lancaster.

What is the study about?
Recently research has focused on the importance of health workers' wellbeing and how this can affect your work satisfaction and performance. Working with challenging populations can impact on your wellbeing and make it difficult to work compassionately with service users. Compassion fatigue is a descriptive term for the negative psychological impacts that can occur from helping others.

This study seeks to measure levels of compassion in staff working directly with people using drugs and/or alcohol. This study will also investigate what contributes to compassion fatigue. The results of this study will improve understanding of what causes compassion fatigue in drug and alcohol workers, and inform recommendations about how the service can reduce compassion fatigue and support health professionals to improve their wellbeing.

Why have I been approached?
You have been approached because the study requires information from people who have at least three months of experience working directly with people who are accessing drug and alcohol services for support. You can participate if you have a paid or unpaid/voluntary/honorary contract with the service you work for.

Do I have to take part?
No. It's completely up to you to decide whether or not you take part.

What will I be asked to do if I take part?
As a participant you will be asked to fill out an online e-survey. The e-survey will include questions about your professional experiences working for drug and alcohol services, how you cope with your work experiences, wellbeing and a test which measures your reactions to words about drug and alcohol use.

Participation in the study will require you to fill out an online e-survey taking a maximum of 30 minutes to fill out. The research team will remain in contact with you regarding timeframes for completing the e-survey. We hope that the online format will make this convenient for you. Paper copies can be made available if you require it. You will be debriefed once you have completed the study.

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Will my data be Identifiable?

No, the e-survey will be anonymous. You will not be asked for your name or any identifiable information.

Data will be stored securely throughout the study under password protection. Your data will be maintained by the research team and kept for a maximum of ten years as standard.

Due to the online nature of the study, consent will also be obtained online. You will be presented with a consent page with a list of statements, continuing with the e-survey will be taken as your informed consent.

What happens to the results?

The results from this project will be written and submitted as part of my training as a clinical psychologist and will be examined by Lancaster University. Your results will be combined with other participants and you will not have access to your own results. We also hope that the results of the study will be published in a peer reviewed journal.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?

This project has been approved by the Faculty of Health and Medicine Research Ethics Committee, and by the University Research Ethics Committee at Lancaster University.

If you would like to take part

If you would like to participate please contact the research team via email, XXXXX. A member of the team will be in touch with you.

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

If you have any questions or require further information you can contact me via email on XXX or my supervisor XXX and we will be happy to answer any questions.

Complaints

If you wish to raise a concern or make a complaint regarding this project and you do not want to report this to the research team, please contact:

Professor Bill Sellwood Program Director, Health Research Tel: +44 (0)1524 593998,

Email: b.sellwood@lancaster.ac.uk Lancaster University

Lancaster LA1 4YG

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

Professor Roger Pickup, Associate Dean for Research, Faculty of Health and Medicine (Division of Biomedical and Life Sciences) Tel: +44 (0)1524 593746

Email: r.pickup@lancaster.ac.uk Lancaster University

Lancaster LA1 4YG

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Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following information may be helpful. Samaritans operate a 24 hour confidential telephone support service and can be contacted for free on Tel: 116 123 (UK). If you are outside the UK, you can contact Befrienders Worldwide, who offers free confidential advice. You can find information, resources and local helplines on their website at http://www.befrienders.org/.

Confidential information and advice about drugs and alcohol is available from http://www.talktofrank.com/. If you feel that you need further support you should speak with your GP or local mental health team for information about supports in your local area.

Thank you in for taking the time to read this information

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Appendix B Participant Consent

Participant Consent Form

What Contributes to compassion Fatigue in Health Professionals Working in Drug and Alcohol Services

Research Team: Ellysia-Grace Thompson (Trainee clinical psychologist), Dr Ian Fletcher (Supervisor, Senior Lecturer at Lancaster University), Dr Adam Huxley (Clinical Psychologist, Change Grow Live), Dr Martin Seager (Clinical Psychologist, Change Grow Live).

We are asking if you would like to take part in a research project on compassion fatigue in health professionals working in drug and alcohol services. Before completing this form, you should have had the opportunity to read the participant information sheet and to ask the research team any questions you might have. If you have any questions or queries before signing the consent form please speak to the principal investigator XXXXXXXXX. **By proceeding with this survey you are giving your consent to each of the statements below.**

1	I have read and understood the participant information sheet
2	I have had the opportunity to ask any questions about the research being conducted
3	I understand that my participation is voluntary and that I am free to withdraw without giving any reason, without my medical care or legal rights being affected.
4	I understand that I will be asked questions about my experiences as a professional.
5	I understand that my data will be collected and stored anonymously.
6	I understand that once my data have been collected it will not be possible for it to be withdrawn.
7	I understand that the information I give will be written up in a report and presented to other professionals. I understand this may be published. My name or identifying details will not be used.
8	I understand that the researcher will discuss data with their supervisor as needed.
9	I understand that the information I give will be stored securely for 10 years on Lancaster University's secure server.
10	I consent to taking part in the study

By proceeding with the survey you are giving consent to the above statement

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Appendix C E-survey measures

What is your gender?

1=male   2= female   3=other

1. How old are you? (free text entry)

2. How long have you worked in drug and alcohol services (years and months)?(free text entry)

3. What is your highest level of education/training? (free text entry)

4. What type of contract do you hold with the service you work for?

1- Paid 2-voluntry/honorary/unpaid

5. How many cases/service users do you work with at any one time?

4= more than 30   3= 20 to 30 cases   2=10 to 20 cases   1= less than 10 cases

6. Have you had personal experience of a drug and/or alcohol problem?

1= yes 2=no

(The Professional Quality of Life (ProQOL)–Revision IV Questionnaire (Stamm, 2009))

Instructions

When you help people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

Scale: 1=Never   2=Rarely   3=Sometimes 4=Often   5=Very Often

1. I am happy.

2. I am preoccupied with more than one person I help.

3. I get satisfaction from being able to help people.

4. I feel connected to others.

5. I jump or am startled by unexpected sounds.

6. I feel invigorated after working with those I help.

7. I find it difficult to separate my personal life from my life as a helper.

8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.

9. I think that I might have been affected by the traumatic stress of those I help.

10. I feel trapped by my job as a helper.

11. Because of my [helping], I have felt "on edge" about various things.

12. I like my work as a helper.

13. I feel depressed because of the traumatic experiences of the people I help.

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14. I feel as though I am experiencing the trauma of someone I have [helped].

15. I have beliefs that sustain me.

16. I am pleased with how I am able to keep up with [helping] techniques and protocols.

17. I am the person I always wanted to be.

18. My work makes me feel satisfied.

19. I feel worn out because of my work as a helper.

20. I have happy thoughts and feelings about those I help and how I could help them.

21. I feel overwhelmed because my case work load seems endless.

22. I believe I can make a difference through my work.

23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.

24. I am proud of what I can do to help.

25. As a result of my [helping], I have intrusive, frightening thoughts.

26. I feel "bogged down" by the system.

27. I have thoughts that I am a "success" as a helper.

28. I can't recall important parts of my work with trauma victims.

29. I am a very caring person.

30. I am happy that I chose to do this work.

(Copenhagen Psychosocial Questionnaire II short questionnaire for assessment of the psychosocial work environment, Kristensen, Hannerz, Høgh, & Borg, 2005)

<u>Instructions</u>

The following questions are about your psychosocial work environment. Please choose the answer that fits best to each of the questions.

Scale: 4- Always   3- Often   2-Some-times   1 –seldom   0- Never/hardly ever

Or

4- To a very large extent   3-To a large extent   2- Some-what   1-To a small extent 0- To a very small extent

1A. Do you get behind with your work?

1B. Do you have enough time for your work tasks?

2A. Is it necessary to keep working at a high pace?

2B. Do you work at a high pace throughout the day?

3A. Does your work put you in emotionally disturbing situations?

3B. Do you have to relate to other people's personal problems as part of your work? 4-

4A. Do you have a large degree of influence concerning your work?

4B. Can you influence the amount of work assigned to you?

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5A. Do you have the possibility of learning new things through your work?

5B. Does your work require you to take the initiative?

6A. Is your work meaningful?

6B. Do you feel that the work you do is important?

7A. Do you feel that your place of work is of great importance to you?

7B. Would you recommend a good friend to apply for a position at your workplace?

8A. At your place of work, are you informed well in advance concerning for example important decisions, changes, or plans for the future?

8B. Do you receive all the information you need in order to do your work well?

9A. Is your work recognised and appreciated by the management?

9B. Are you treated fairly at your workplace?

10A. Does your work have clear objectives?

10B. Do you know exactly what is expected of you at work?

11A. To what extent would you say that your immediate superior gives high priority to job satisfaction?

11B. To what extent would you say that your immediate superior is good at work planning?

12A. How often is your nearest superior willing to listen to your problems at work?

12B. How often do you get help and support from your nearest superior?

13. Regarding your work in general. How pleased are you with your job as a whole, everything taken into consideration?

The next two questions are about the way your work affects your private life and family life.

14A. Do you feel that your work drains so much of your energy that it has a negative effect on your private life?

3- Yes, certainly   2-Yes, to a certain degree   1-Yes, but only very little 0-No,not at all

14B. Do you feel that your work takes so much of your time that it has a negative effect on your private life?

15A. Can you trust the information that comes from the management?

15B. Does the management trust the employees to do their work well?

16A. Are conflicts resolved in a fair way?

16B. Is the work distributed fairly?

Instructions

The following five questions are about your own health and well-being. Please do not try to distinguish between symptoms that are caused by work and symptoms that are due to other causes. The task is to describe how you are in general.

The questions are about your health and well-being during the last four weeks:

Sclae 4- All the time   3-A large part of the time   2-Part of the time   1-A small part of the time   0-Not at all

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17. In general, would you say your health is:

4-Excellent   3-Very good   2-Good   1-Fair 0-Poor

18A. How often have you felt worn out?

18B. How often have you been emotionally exhausted?

19A. How often have you been stressed?

19B. How often have you been irritable?

20. Have you been exposed to undesired sexual attention at your workplace during the last 12 months?

  4- Yes, daily   3-Yes, weekly 2-Yes, monthly   1-Yes, a few times   0-No

  If yes, from whom? (You may tick off more than one)

  3-Colleagues   2-Manager/supervisor 1-Sub-ordinates   0- Clients/patients

21. Have you been exposed to threats of violence at your workplace during the last 12 months?

  4-Yes, daily   3-Yes, weekly 2-Yes, monthly   1-Yes, a few times   0-No

  If yes, from whom? (You may tick off more than one)

  3-Colleagues   2-Manager/supervisor 1-Sub-ordinates   0- Clients/patients

22. Have you been exposed to physical violence at your workplace during the last 12 months?

  4-Yes, daily   3-Yes, weekly 2-Yes, monthly   1-Yes, a few times   0-No

  If yes, from whom? (You may tick off more than one)

  3-Colleagues   2-Manager/supervisor 1-Sub-ordinates   0- Clients/patients

  Instructions

  Bullying means that a person repeatedly is exposed to unpleasant or degrading treatment, and that the person finds it difficult to defend himself or herself against it.

23. Have you been exposed to bullying at your workplace during the last 12 months?

  4-Yes, daily   3-Yes, weekly 2-Yes, monthly   1-Yes, a few times   0-No

  If yes, from whom? (You may tick off more than one)

  3-Colleagues   2-Manager/supervisor 1-Sub-ordinates   0-

  Clients/patients

  (Emotion Contagion Scale, Siebert, Siebert, & Taylor-McLaughlin, 2007)

  Scale: 5 –strongly agree 4-agree 3-somewhat agree 2- disagree 1-strongly disagree

  1.   I often find that I can remain cool in spite of excitement around me.

  2.   I am able to remain calm even though those around me worry.

  3.   I cannot continue to feel okay if people around me are depressed.

  4.   I become nervous if others around me seem to be nervous.

  5.   The people around me have a great influence on my moods.

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(Emotional regulation questionnaire, Gross, & John, 2003)

Instructions

We would like to ask you some questions about your emotional life, in particular, how you control (that is, regulate and manage) your emotions. The questions below involve two distinct aspects of your emotional life. One is your emotional experience, or what you feel like inside. The other is your emotional expression, or how you show your emotions in the way you talk, gesture, or behave. Although some of the following questions may seem similar to one another, they differ in important ways. For each item, please answer using the following scale:

Scale:

1-----------2-------------3---------------4-------------5-------------6------------7

Strongly agree   Neutral   Strongly disagree

1. When I want to feel more positive emotion (such as joy or amusement), I change what I'm thinking about.

2. I keep my emotions to myself.

3. When I want to feel less negative emotion (such as sadness or anger), I change what I'm thinking about.

4. When I am feeling positive emotions, I am careful not to express them.

5. When I'm faced with a stressful situation, I make myself think about it in a way that helps me stay calm.

6. I control my emotions by not expressing them.

7. When I want to feel more positive emotion, I change the way I'm thinking about the situation.

8. I control my emotions by changing the way I think about the situation I'm in.

9. When I am feeling negative emotions, I make sure not to express them.

10. When I want to feel less negative emotion, I change the way I'm thinking about the situation.

Question adapted from Von Hippel (2008)

Scale: 5- Strongly agree   4- agree   3-somewhat agree   2-disagree   1- strongly agree

1. During the next year, I will probably look for a new job in another area.

2. Working with drug/alcohol users is really a strain for me

3. Working with drug/alcohol users directly puts too much stress on me.

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Appendix D Implicit Association Test

Target A	Drug user, substance abuser, drug addict, alcoholic, drinker and addiction
Target B	Fat, obese, overweight, heavy, morbidly obese, large
Evaluation A	Good, Affection, Care , Grateful, Warmth, Hopeful, Considerate, Understanding, Protective
Evaluation B	Bad, Challenging, Difficult, Selfish, Weak, Ungrateful, Stressful, Unpleasant, Irresponsible

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Appendix E Debrief

Thank you for taking the time to participate in this study. Compassion fatigue is a term describing the negative psychological impacts of helping others (Stamm 2012). It has been suggested that being exposed to people's experiences of drug/alcohol use and the associated adversity can be highly emotive, and drug and alcohol workers may be at risk of developing compassion fatigue (Fahy, 2007). The purpose of this study is to apply what is already known about the causal factors of compassion fatigue to professionals working in drug and alcohol services. The results of this study will improve understanding of what causes compassion fatigue in drug and alcohol workers.

All the information we collected in the study will be anonymously, and there will be no way of identifying your responses in the data. Your data will be combined with all the other participants who take part in the study and we will look at the general patterns that emerge.

Should you feel distressed either as a result of taking part, or in the future, the following information may be helpful. Samaritans operate a 24 hour confidential telephone support service and can be contacted for free on Tel: 116 123 (UK). If you are outside the UK, you can contact Befrienders Worldwide, who offers free confidential advice. You can find information, resources and local helplines on their website at

Confidential information and advice about drugs and alcohol is available from http://www.talktofrank.com/. If you feel that you need further support you should speak with your GP or local mental health team for information about support in your local area.

If you have any questions about the study you can contact Ellysia-Grace Thompson via email on e.thompson4@lancaster.ac.uk or my supervisor Dr Ian Fletcher i.fletcher@lancaster.ac.uk and we will be happy to answer any questions.

Thank you for participating.