

How do psychologists and high intensity therapists
understand and engage in self-care?

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ABSTRACT

Background: The demanding nature of therapeutic work, along with associated stressors and risk factors, puts therapists at risk of stress and distress. If unchecked, this may affect their psychological wellbeing and professional competence (Wise & Barnett, 2016). Engagement in self-care has been suggested not only to be protective against such outcomes, but as therapists' ethical responsibility (Wise, Hersh, & Gibson, 2012). Therapist self-care has not previously been studied in the context of the National Health Service (NHS), where increasing pressures may be a barrier to both compassionate care of others and practitioner psychological wellbeing (Francis, 2013).

Aims: This study sought to explore how psychologists and high intensity therapists working in the NHS understand and engage in self-care, and well as exploring what facilitates and hinders self-care.

Method: A critical realist approach was adopted. Four focus groups took place, each with four participants who were qualified National Health Service clinical psychologists, counselling psychologists, or high intensity therapists. Thematic analysis was used to analyse transcripts.

Results: Three main themes were generated: 'Self-care as restorative activities'; 'Self-care as a way of being'; and 'The challenge of self-care in the NHS'. A description of these themes and associated subthemes is presented.

Conclusions: The study reflected the literature in concluding that self-care is complex, and can be understood as multifaceted. The study added to the literature by suggesting that these facets may be understood as restorative activities and ways of being, and that self-care can be proactive or reactive. Results suggested that facilitators and barriers to self-care can be understood in terms of individual factors (one's own attitudes or stance towards self-care), relational factors (the influence of others), and systemic factors (the effect of wider pressures). The findings highlight the significant challenges of engaging in self-care in the context of the NHS, where pressures and expectations are high. Practical implications and directions for future research are discussed.

TABLE OF CONTENTS

1. INTRODUCTION.....	1
1.1 Definition of Terms	1
1.1.1 Self-Care	1
1.1.2 Career-Sustaining Behaviours	1
1.1.3 Burnout	2
1.1.4 Compassion Fatigue	2
1.1.5 Wellness	2
1.1.6 Distress	2
1.2 Literature Search	2
1.3 Conceptualisation of Self-Care	3
1.3.1 Personal and Professional Self-Care	4
1.3.2 Measures of Self-Care	4
1.3.3 Summary	6
1.4 Stress and Psychological Distress Experienced by Therapists	6
1.4.1 Psychological Wellbeing in Therapists	7
1.4.2 Context of the NHS	8
1.4.3 Impact of Stress and Psychological Distress	9
1.4.4 Summary	12
1.5 Self-care and Psychological Wellbeing: A Summary of Key Studies	12
1.5.1 Mechanisms of Self-Care	15
1.5.2 Summary	17
1.6 Self-Care as an Imperative	17
1.6.1 Ethical Imperative to Self-Care	17
1.6.2 Proactive Self-care to Prevent Impairment	18
1.7 Self-Care Recommendations	19
1.7.1 Critique of Self-Care Recommendations	19
1.8 Therapists' Engagement in Self-Care: A Summary of Key Studies	21
1.8.1 Beliefs About Self-Care	21
1.8.2 Engagement in Self-Care	23
1.8.3 Relationship Between Beliefs and Engagement	25
1.8.4 Summary	26
1.9 Barriers to Self-Care	26
1.9.1 Self-Care: An Individual's Responsibility?	27

1.10 Rationale for Current Study	28
1.10.1 Research Questions	29
2. METHODOLOGY AND METHOD	30
2.1 Epistemological and Ontological Position	30
2.2 Qualitative Methodology	31
2.2.1 Choice of Approach.....	31
2.2.2 Focus Groups	34
2.3 Ethical Considerations	34
2.3.1 Ethical Approval	34
2.3.2 Informed Consent and Debrief	35
2.3.3 Data Security	35
2.4 Data Collection	35
2.4.1 Recruitment.....	36
2.4.2 Focus Groups	36
2.4.3 Participants	37
2.4.4 Interview Schedule.....	38
2.5 Data Analysis	38
2.5.1 Transcription	38
2.5.2 Analysis	38
2.6 Reflexivity	40
2.7 Evaluation	41
3. ANALYSIS	42
3.1 Self-care as Restorative Activities	43
3.1.1 Restoring the Person	43
3.1.2 Restoring the Worker	45
3.1.3 Proactive and Reactive Self-Care.....	47
3.2 Self-care as a Way of Being	49
3.2.1 Being Aware	49
3.2.2 Being Boundaried	52
3.2.3 Being Aligned with Values	54
3.2.4 Self-Compassion.....	57
3.3 The Challenge of Self-care in the NHS.....	58
3.3.1 Influence of Team Culture	58
3.3.2 Influence of Organisational Culture.....	60
3.3.3 Self-Care Agenda in the NHS	62

4. DISCUSSION	64
4.1 Present Findings in Relation to the Literature and the Research Questions	64
4.1.1 How do NHS Psychologists and High Intensity Therapists Describe Their Understanding of Self-Care?	64
4.1.2 How do NHS Psychologists and High Intensity Therapists Describe Their Engagement in Self-Care?	69
4.1.3 How do NHS Psychologists and High Intensity Therapists Describe Their Views on What Facilitates Self-Care?	70
4.1.4 How do NHS Psychologists and High Intensity Therapists Describe Their Views on What Hinders Self-Care?	72
4.2 Implications for Practice.....	74
4.2.1 Individual Level	74
4.2.2 Team Level.....	74
4.2.3 Wider Systems Level	75
4.3 Implications for Further Research.....	76
4.4 Critical Review	77
4.4.1 Quality Within Qualitative Research	77
4.4.2 Generalisability	79
4.4.3 Epistemological and Methodological Reflexivity	80
4.5 Reflexive Review	81
4.5.1 My Understanding of Self-Care.....	81
4.5.2 Power and Roles Within the Focus Groups	82
4.5.3 My Relationship with Self-Care	83
4.6 Conclusion	84
REFERENCES	86
APPENDIX A: RESEARCH JOURNAL	102
APPENDIX B: UEL ETHICAL APPROVAL APPLICATION	104
APPENDIX C: UEL ETHICAL APPROVAL CONFIRMATION	113
APPENDIX D: HRA ETHICAL APPROVAL CONFIRMATION	116
APPENDIX E: HRA AMMENDMENT CONFIRMATION	123
APPENDIX F: R&D APPROVAL.....	124
APPENDIX G: INFORMATION SHEET	127
APPENDIX H: CONSENT FORM.....	130
APPENDIX I: DEBRIEF SHEET	131
APPENDIX J: DEMOGRAPHICS FORM	132
APPENDIX K: INTERVIEW SCHEDULE	133

APPENDIX L: ANNOTATED TRANSCRIPT EXAMPLE	135
APPENDIX M: CODED TRANSCRIPT EXTRACT	136
APPENDIX N: LIST OF CODES	138
APPENDIX O: EXAMPLE CODES WITH ASSOCIATED EXTRACTS	141
APPENDIX P: FIRST PRELIMINARY THEMATIC MAP	145
APPENDIX Q: SECOND PRELIMINARY THEMATIC MAP	146
APPENDIX R: FINAL THEMATIC MAP	147

LIST OF TABLES AND FIGURES

Table 1. Participant characteristics	37
Figure 1. Final thematic map	42

1. INTRODUCTION

This chapter will begin by introducing the concept of self-care within the academic literature. I will then go on to discuss therapist psychological wellbeing and the risks of therapeutic work, which are exacerbated by the current context of the National Health Service (NHS). Research into the relationship between self-care and psychological wellbeing will be explored, before considering the proposal of proactive self-care as an ethical imperative for therapists. Recommendations about the self-care practice will then be considered, before the discussion of the research into therapists' engagement in self-care. Highlighting the limited research into barriers to self-care, as well as the absence of studies exploring NHS therapists' self-care, I will present the rationale and aims for the current study.

1.1 Definition of Terms

Self-care and related terms are defined below. The conceptualisation of self-care is explored further in section 1.3.

1.1.1 Self-Care

The origin of the term 'self-care' is unclear, but it was suggested by Wise and Barnett (2016) that the term was first used in the 12-step recovery movement. Self-care has been defined as "routine positive practices and mindful attention to one's physical, emotional, relational, and spiritual selves in the context of one's personal and professional lives" (Wise & Barnett, 2016, p. 210).

1.1.2 Career-Sustaining Behaviours

The term career-sustaining behaviours is sometimes used in the literature as an alternative to self-care (Brownlee, 2016). The term tends to emphasise professional functioning and satisfaction, and is defined as behaviours "used to enhance, prolong, and make more comfortable one's work experience" (Brodie, 1982, p. 1).

1.1.3 Burnout

According to Maslach and Jackson (1981), burnout is a syndrome comprised of three aspects: emotional exhaustion, depersonalisation, and reduced sense of personal accomplishment.

1.1.4 Compassion Fatigue

Defined by Figley (2002), compassion fatigue is the combination of a reduced capacity to be present with clients, and feelings of powerlessness, isolation and confusion.

1.1.5 Wellness

Myers, Sweeney, and Witmer (2000) defined wellness as “a way of life oriented towards optimal health and well-being in which body, mind, and spirit are integrated by the individual to live more fully within the human and natural community” (p. 252).

1.1.6 Distress

Distress has been defined as “the subjective emotional response an individual experiences in response to any of a number of challenges, demands, and stresses in one’s life” (Barnett, Johnston, & Hillard, 2006, p. 258).

1.2 Literature Search

In order to conduct a thorough review of the literature, I used a number of search strategies, in line with Booth, Sutton, and Papaioannou’s (2016) recommendations.

I conducted a database search with the following search terms: clinical psycholog* OR counselling psycholog* OR “therap* OR psychotherap* AND self-care OR self care OR compassion fatigue OR burnout OR career-sustaining behavi* OR career sustaining behavi*. The databases searched were: PSYCHINFO, Scopus, Academic Search Complete, CINAHL, Science Direct and Google Scholar. All databases were searched from their start date to January 2018; due to resource limitations, the search was restricted to those written in English. Following this, key authors were searched to include any of

their relevant publications that may not have appeared in the initial search. In addition, a citation search was completed, where relevant citations from key papers were also accessed.

A narrative, rather than systematic review is recommended when a particular area requires further clarification and insight (Greenhalgh, Thorne, & Malterud, 2018). As self-care is not well defined or conceptualised in the literature (Dorociak, Rupert, Bryant, & Zahniser, 2017), a narrative review seemed appropriate. This was supported by the nature of much of the self-care literature: many relevant publications are theoretical, and would therefore have been excluded by a more systematic methodology. This chapter therefore contains a narrative review of the self-care literature as related to therapists.

1.3 Conceptualisation of Self-Care

There does not appear to be a consensus on how the term self-care is conceptualised in the literature (Lee & Miller, 2013). Self-care has been described as specific activities (Carroll, Gilroy, & Murra, 2003; Jordan, 2010), as health behaviours (Pender, Murdaugh, & Parsons, 2010), as a process (Dorociak et al., 2017), as an ability (Collins, 2005), as strategies (Wise & Barnett, 2016), as techniques (Skovholt, Greer, & Hanson, 2001), as an art and science (Wise, Hersh, & Gibson, 2012), as principles (Norcross & Guy, 2007), and as an approach (Rupert, Miller, & Dorociak, 2015). Self-care has also been described as a means to obtain positive outcomes (Lee & Miller, 2013), to create resiliency (Stebnicki, 2007), to provide stress relief (Brucato & Neimeyer, 2009), and to avoid compassion fatigue or burnout (Alkema, Linton, & Davis, 2008; Rupert et al., 2015; Skovholt et al., 2001).

This lack of consensus makes it difficult to draw conclusions about the concept, however there appears to be a broad agreement that self-care is multifaceted (Dorociak et al., 2017). A number of authors make suggestions about the facets which may comprise self-care, commonly highlighting the areas of physical, psychological or emotional, relational, and spiritual wellbeing (e.g. Carroll, Gilroy, & Murra, 1999; Malinowski, 2014; Richards, Campenni, & Muse-Burke, 2010; Skovholt et al., 2001; Warren, Morgan, Morris, & Morris, 2010). Indeed, in a review of the self-care literature, Wise and Barnett (2016) found physical,

emotional, relational, and spiritual wellbeing commonly emerged as dimensions of self-care. This was similar to the three factor model of self-care proposed by Sanata and Fouad (2017), of cognitive-emotional-relational, physical, and spiritual factors.

1.3.1 Personal and Professional Self-Care

As well as a lack of consensus about what self-care actually is, there is disagreement in the literature about whether a distinction should be drawn between personal and professional self-care. Lee and Miller (2013) argued that these as two separate but interconnected dimensions. Similarly, a qualitative study conducted with seven UK counsellors about self-care categorised self-care into personal and professional domains (Brownlee, 2016).

However, Bressi and Vaden (2017) critiqued this conceptualisation of the self, suggesting that this split is a pre-modern understanding of the self which implies that the professional self requires protection from the 'encroachment' of the personal self, and vice versa. Bressi and Vaden suggested that there has been a paradigm shift in how the self is understood and used in the helping professions. They proposed that the self is commonly considered as whole, without different selves for different roles; they also drew on the notion of the use of the self in therapeutic work, considered to be a core competency in therapy (Baldwin, 2013; Corey, 2005). Miller and Sprang (2017) similarly suggested that a distinction should not be drawn between personal and professional self-care.

1.3.2 Measures of Self-Care

Until recently, an additional challenge to self-care research has been the lack of an empirically based, psychometrically sound measure of self-care (Dorociak et al., 2017). Two measures frequently used to assess self-care are discussed below¹, followed by two promising new measures.

¹ Self-care measures developed for an individual study are described and critiqued when reporting the studies. Additionally, a few studies employed measures not typically used to assess self-care, critiqued when the studies are discussed.

1.3.2.1 Self-Care Assessment Worksheet (SCAW; Saakvitne, Pearlman, & Abrahamson, 1996)

The SCAW is a 60-item reflective tool created to support therapists in their self-care. It includes activities under the domains: physical, psychological, emotional, spiritual, professional workplace, and life balance. Participants rate how frequently they engage in each behaviour on a Likert scale. However, as highlighted by Santana and Fouad (2017), the SCAW is not a standardised or validated measure as it was developed as a reflective worksheet. Additionally, it should not be assumed that the frequency of a behaviour relates to its utility or efficacy.

1.3.2.2 Career-Sustaining Behaviors Questionnaire (CSBQ; Brodie, 1982)

The CSBQ is used to ascertain which behaviours therapists rate as more or less important in helping them to function effectively and maintain a positive attitude in their professional role; a Likert scale is used to rate each behaviour. The CSBQ was originally developed by Brodie, but has been modified by numerous authors to shorten the measure as the original was 17 pages (e.g. Kramen-Kahn & Hansen, 1998; Lawson & Myers, 2011; Schkolnik, 1984; Stevanovic & Rupert, 2004). The frequent modification of this measure calls into question its validity. This measure also has particular limitations in terms of its use in measuring self-care: as it was developed to assess career-sustaining behaviours in relation to professional functioning, it cannot be assumed to relate directly to self-care.

1.3.2.3 Professional Self-Care Scale (PSCS; Dorociak et al., 2017)

Developed specifically to measure self-care, the PSCS is comprised of 21 items which load onto five factors: professional support, professional development, life balance, cognitive awareness, and daily balance. These were developed through factor analysis of items drawn from the self-care literature. The reliability and validity of the measure were reported to be acceptable (Dorociak et al., 2017).

Although the PSCS appears promising, it is important to note that some factors were excluded from the final measure. Dorociak et al. noted the absence of factors they label as reactive self-care (e.g. reducing workload, seeking guidance, and counselling), and physical factors (e.g. sleep and exercise). They

explained that in analysis, items within these factors did not load onto meaningful constructs so were not included, despite frequent references in the self-care literature.

1.3.2.4 Self-Care Behaviors Inventory (SCBI; Santana & Fouad, 2017)

The SCBI is formed of 19 items which load onto three factors: cognitive-emotional-relational, physical, and spiritual. The SCBI was developed from the SCAW. Qualitative feedback from 28 trainee psychologists was used to refine and reword the SCAW items. Following completion of the resulting 48 items by 169 trainee psychologists, components analysis resulted in the production of the three factor model. The reliability and validity of the final measure were reported to be acceptable (Santana & Fouad, 2017). No cut offs were suggested, as the measure was developed to support trainee psychologists in maintaining an awareness of self-care. As such, further research is required to ascertain whether the measure could also be used to study self-care outcomes.

1.3.3 Summary

As demonstrated, beyond an agreement that self-care is multifaceted, there does not appear to be a consensus in the literature about what self-care actually is. Facets frequently proposed to comprise self-care relate to physical wellbeing, psychological or emotional wellbeing, relational wellbeing, and spiritual wellbeing. There is also a lack of agreement in the literature about whether a distinction should be drawn between personal and professional self-care. The evidence base has also been limited by the lack of a self-care measure, however the recent developments of the PSCS and SCBI may redress this deficit in future.

1.4 Stress and Psychological Distress Experienced by Therapists

Despite the lack of consensus in the literature, numerous recommendations have been made about how and why therapists should engage in self-care. These arguments often centre around stress and psychological distress. This section explores the stress and psychological distress experienced by therapists. The demanding nature of therapeutic work is discussed, as well as additional stressors related to working in the NHS. Potential effects of stress

and psychological distress are explored, with a discussion of compassion fatigue and burnout.

1.4.1 Psychological Wellbeing in Therapists

Therapeutic work can be emotionally and psychologically demanding (Norcross & Guy, 2007; Skovholt et al., 2001), a toll exacerbated by additional stressors involved, such as administrative tasks and service demands (Wise & Barnett, 2016). Reporting common stressors and causes of psychological distress for therapists, Cooper (2009) found that challenging clients was cited by 91% of therapists sampled, documentation and record keeping by 91%, 59% highlighted managed care, risk of client suicide was cited by 54%, financial pressure by 50% of therapists, and 47% cited concerns about ethics or licence board complaints.

In addition, therapists are no less likely than others to experience challenges in their personal lives, as well as mental health concerns (Barnett, Baker, Elman, & Schoener, 2007). Indeed, it has been suggested that the experience of difficulties or trauma can be a draw towards therapeutic work (Barnett, 2008; Leiper & Casares, 2000). Surveying 500 psychologists in America, Pope and Feldman-Summers (1992) found over two thirds of the women and one third of the men had experienced physical or sexual abuse. Similarly, in a sample of 340 female mental health professionals in America, Elliot and Guy (1993), found 69% had a childhood trauma history.

It would appear that levels of psychological distress in therapists are high: a survey of 1106 psychologists in the UK (Rao et al., 2017) found self-reported depression was reported by 46% of participants, an increase from 40% reported in the same survey in 2014. In America, the American Psychological Association (APA) found that 40-60% of psychologists reported symptoms related to burnout, anxiety and/or depression (APA, 2010).

Similar results have been found in trainees. Surveying 119 psychology trainees across America, Rummell (2015) found their rates of physical and mental health symptomatology were higher than those of the general population and of medical students, with over half reporting anxiety, and almost two fifth symptoms of depression, at a clinically significant level.

Of concern, some therapists may have a “professional blindspot” (Barnett & Cooper, 2009, p.16), perceiving it unlikely that they would experience mental health problems themselves. Furthermore, when therapists do identify areas of difficulty, evidence suggests they can be hesitant to seek support (Barnett & Hillard, 2001). Potential reasons for this may include fear that disclosing difficulty may affect their professional reputation, and feeling a need to be ‘strong’ (Barnett & Hillard, 2001).

1.4.2 Context of the NHS

Concerns about therapists’ psychological wellbeing are particularly important in the current context of mental health services. This is most notable in the NHS, which is continually being asked to do more with fewer resources (Wilkinson, 2015), with staff being put under pressure of increased work demands and expected to reach higher performance targets (Felstead, Gallie, Green, & Inanc, 2013).

Recent statistics have shown a higher sickness absence rate in NHS mental health services than in other NHS services, as well as higher sickness absence rates in the NHS as compared with other sectors (Quality Watch, 2015). A recent collaboration between the Division of Clinical Psychology and New Savoy Conference (Rao et al., 2017) found 70% of the 1106 UK psychologists surveyed reported finding their job stressful often or all of the time, while 45% indicated that they did not have a good quality of working life (as compared to the NHS norm of 36%). In the same study, 46% of participants reported experiencing depression, and almost 50% indicated that they have felt like a failure.

As well as affecting psychological wellbeing, high levels of stress and psychological distress in staff have an adverse effect on care, patient or client experiences, and outcomes (West & Dawson, 2015). The Francis Report (2013) raised concerns about the systemic failure of compassionate care provision in the NHS, as well as the climate of fear created around bringing attention to inadequate care. The report went on to emphasise how increasing scrutiny and pressures faced by the NHS are unlikely to lead to a compassionate organisational culture. Egan, Mantzios, and Jackson (2016) similarly raised

concerns that a focus on practice and outcomes at an individual (staff member) level may increase staff burnout and decrease staff self-care. Such potential effects of stress and psychological distress are explored further below.

1.4.3 Impact of Stress and Psychological Distress

Wise and Barnett (2016) emphasised that if psychological distress is not attended to, it may affect professional functioning and competence, as well as personal psychological wellbeing. Witmer and Young (1996) highlighted that “well counsellors are more likely to produce well clients” (p. 151); equally, impaired therapists are more likely to harm clients (Lawson, Venart, Hazier, & Kottler, 2007).

This is conceptualised by the APA Advisory Committee on Colleague Assistance in the stress-distress-impairment-improper behaviour continuum (n.d.). This model elucidates the mechanism by which unmanaged stress is translated into impairment (such as difficulty managing work in a timely manner) and improper behaviour (such as behaviour that crosses ethical boundaries) via a “progressive downward spiral” (Wise et al., 2012, p. 488).

Although difficult to locate recent statistics in the literature (Smith & Moss, 2009), there are indications that levels of therapist impairment related to psychological distress may be high. Guy, Poelstra, and Stark (1989) surveyed 749 psychologists across America, finding almost 75% reported experiencing distress within the prior three years, with 36.7% of those acknowledging that their distress decreased the quality of care they provided; 4.6% acknowledged that as a result of their own distress, the care they provided clients was inadequate. Similarly, Pope, Tabachnick, and Keith-Spiegel (1987) found of 456 psychologists surveyed across America, 59.6% reported that they have worked when too distressed to be effective, and 85% of those acknowledged that to do so is unethical. Although these studies took place a number of years ago, more recent data indicates that the situation may not have altered: the APA (2010) explored the prevalence of impairment in its members, finding almost two thirds of 658 participants reported knowing a therapist they considered to be impaired.

The terms compassion fatigue and burnout have been used to describe the effects of stress and psychological distress on professional functioning and

individual psychological wellbeing (Skovholt et al., 2001). The proposed causes and effects of compassion fatigue and burnout are explored further below, along with the concepts' construct validity.

1.4.3.1 Compassion fatigue

Sinclair, Raffin-Bouchal, Lorraine, and Smith-Macdonald (2017) summarised the effects of compassion fatigue in their recent review of the topic, categorising over 40 proposed consequences into physical, behavioural, psychological, and spiritual effects. Physical effects included factors such as exhaustion, insomnia, and somatisation. Behavioural effects included absenteeism, impaired clinical decision making, and 'The Silencing Response' (diverting conversation away from traumatic memories and/or referring onward [Baranowsky, 2002]).

Psychological effects included emotional exhaustion, depression, reduced empathy, and cynicism. Spiritual effects included a disinterest in introspection, poor judgement, and a decrease in wisdom.

Considering causes of compassion fatigue, Figley (1995) proposed an eleven-factor model of compassion fatigue, based on his observations of psychotherapists. This model posited that exposure to a client's emotion elicits empathy, where the therapist experiences the client's emotions and results in compassion stress in the therapist. Unless attended to, this compassion stress has negative psychological and physiological effects, ultimately leading to compassion fatigue. Figley (1995) proposed that particularly traumatised clients, extensive exposure to client trauma, and negative life events contribute to compassion fatigue, while a sense of achievement, and disengagement from stress make compassion fatigue less likely. A key implication of this model is that therapists should limit their empathic engagement in order to reduce likelihood of compassion fatigue.

However, this model has been criticised for unclear definitions, its linear nature, a binary conceptualisation of compassion fatigue, and for proposing that by its very nature, compassion results in compassion fatigue (Fernando & Consedine, 2014; Miller & Sprang, 2017; Sabo, 2011). Of particular note is the limited empirical support for the notion that compassion fatigue occurs because clinicians care too much (Miller & Sprang, 2017). Instead, Miller and Sprang

suggested that harm related to working with distressed clients may be due to the attempted avoidance or inhibition of difficult feelings. This was based on evidence supporting Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2011), which suggests that willingness to experience difficult feelings mediates the effects of psychological distress (Hayes et al., 2011). Therefore, Figley's (1995) suggestion that therapists should limit their empathic engagement should not be accepted without careful consideration.

Looking at evidence for possible causes of compassion fatigue in mental health professional, a recent review by Turgoose and Maddox (2017) found that the factors most commonly associated with compassion fatigue were a professional's own trauma history, and the nature of their caseload. There were contradictory findings in the literature about the relationship between empathy and compassion fatigue; Turgoose and Maddox (2017) highlighted that longitudinal research is needed to clarify the relationship and establish causality. However, following a review of the literature, Sinclair et al. (2017) suggested that compassion fatigue could be considered a euphemism for a range of stressors attributed to care providers, and concluded that compassion fatigue does not have sufficient construct validity to be empirically validated or measured. This suggests that care should be taken in drawing firm conclusions about the concept.

1.4.3.2 Burnout

Burnout has been called an occupational hazard of working in mental health (Maslach, 1986; Maslach, Schaufeli, & Leiter, 2001). Burnout has been said to contain many components typically associated with compassion fatigue, as well as further emotional exhaustion, reduced personal accomplishment, and an apathy for one's work (Dattilio, 2015).

Rupert et al. (2015) summarised factors associated with an increased or decreased risk of burnout. They found that certain work factors are associated with an increased risk, including longer working hours, more time spent on administrative tasks, stressful client behaviours, and feeling over-involved with clients. Work factors found to reduce the risk of burnout included a sense of control and personal support. Certain personal resources and coping strategies

were also found to decrease the risk of burnout, including family support, self-care, self-awareness, social support, cognitive coping skills, and problem-focussed coping (as contrasted to avoidant-focussed coping). Increased years of practice appears to be associated with reduced burnout (Di Benedetto & Swadling, 2014), however, this may be due to a drop-out effect of those who experience burnout leaving the profession.

As with compassion fatigue, it has been proposed that empathy is a risk factor for burnout (Figley, 2002; Rothschild, 2006). Wilkinson, Whittington, Perry, and Eames (2017) conducted a systematic review of studies examining burnout and empathy across a range of professions and settings. Interestingly, they found that increased empathy was associated with lower levels of burnout. However, as the research reviewed was correlational, a causal relationship between empathy and burnout cannot be inferred.

In terms of the construct validity of compassion fatigue, Sinclair et al. (2017) highlighted a lack of clear empirical distinction between compassion fatigue and burnout. Once again, this indicates that care must be taken in drawing firm conclusions from research about either concept.

1.4.4 Summary

This section explored the stress and psychological distress commonly experienced by therapists, particularly for those working in an NHS setting. The potential consequences of such stress and psychological distress are often framed in the literature as burnout or compassion fatigue. As well as self-care, avoiding empathic engagement has been suggested as a means to avoid such experiences, however this proposal does not have firm empirical support. Furthermore, the lack of construct validity for burnout and compassion fatigue makes it difficult to draw any firm conclusions about either.

1.5 Self-care and Psychological Wellbeing: A Summary of Key Studies

In section 1.4 I presented an argument that it is common for therapists to experience stress and psychological distress, which have the potential for concerning consequences. Self-care has been proposed as a means to avoid such consequences (e.g. Skovholt et al., 2001), as it is considered to improve

psychological wellbeing (Wise et al., 2012). This section explores the relationship between self-care and psychological wellbeing by summarising and critiquing studies that have investigated the topic in therapists. This section then goes on to look at mindfulness and self-compassion, which have been proposed as key to the positive effects self-care may incur.

Studying 506 counsellors in America, Lawson and Myers (2011) found that those who rated career-sustaining behaviours as more important on the CSBI scored more highly on measures of wellbeing (the Five Factor Wellness Inventory [Myers & Sweeney, 2004] and the Professional Quality of Life scale [ProQOL; Stamm, 2005]). Likewise, Kramen-Kahn and Hansen (1998) surveyed 208 psychotherapists in America, and found that those who reported placing a greater importance on career-sustaining behaviours also tended to report greater occupational rewards (such as increased self-knowledge and enjoyment of work). These results are promising, however the focus on career-sustaining behaviours, limits the implications for self-care.

Richards et al. (2010) found a significant positive correlation between reported self-care frequency and psychological wellbeing, and a weaker, but significant, positive correlation between rated importance of self-care and psychological wellbeing. The study was a survey of 148 mental health professionals in America, including psychologists and counsellors. The study used the Schwartz Outcome Scale-10 (Blais et al., 1999) to measure wellbeing, and a measure of self-care was developed for the study: participants were asked to rate on a Likert scale how often they engaged in behaviours related to physical, psychological, spiritual and support aspects of self-care, and how important they considered each aspect to be. However, as this measure's reliability and validity were not established, conclusions must be drawn with caution.

Alkema et al. (2008) surveyed 37 hospice care staff in America, finding a relationship between increased engagement in self-care (as measured by the SCAW) and lower levels of compassion fatigue, as well as higher levels of compassion satisfaction (both measured by the the ProQOL). Similarly, in a survey of 46 therapists in America, Catlin-Rakoski (2012) found a negative relationship between self-care engagement and burnout. This study also used the SCAW and ProQOL. However, because of the previously discussed

limitations of the SCAW and concepts of burnout and compassion fatigue, as well as the studies' small sample sizes, the reliability, validity and generalisability of the studies could be questionable.

Similar results were found by Ganey (2005), who surveyed 190 psychologists in America. Ganey found an association between reporting of higher engagement in career-sustaining behaviours on the CSBI, and lower levels of reported burnout and emotional depletion. However, the focus on career-sustaining behaviours limits the conclusions that can be drawn from this study about self-care.

Finally, Martin-Johnson (2016) used multiple regression to explore the relationship between self-care and burnout in 325 mental health practitioners in New York using the Brief COPE (Carver, 1997) as a measure of self-care, and the Maslach Burnout Inventory - Human Services Survey (Maslach & Jackson, 1986). Although this study found that the Brief COPE significantly predicted experiences associated with burnout (depersonalisation, emotional exhaustion, and reduced personal accomplishment), the measure was developed as an assessment tool for a broad range of coping resources, which may not be equivalent to self-care.

In conclusion, these studies tentatively suggest a positive relationship between self-care and psychological wellbeing, but this conclusion should be drawn with care due to the discussed methodological limitations. Furthermore, due to the cross-sectional design of these studies, a causal relationship cannot be established. The studies appear to have an underlying assumption that self-care improves psychological wellbeing, however it may be that those with increased wellbeing are more likely to rate self-care as more important or indicate that they engage in self-care more often. Further research using validated measures and a longitudinal design is thus required in order to better understand this relationship. Furthermore, without an agreed conceptualisation of self-care in the literature, it must not be assumed that studies looking at self-care share an understanding of the concept.

1.5.1 Mechanisms of Self-Care

Although a causal relationship between self-care and psychological wellbeing has not been established empirically, a number of publications have explored potential underlying characteristics of self-care which may have positive effects on psychological wellbeing.

1.5.1.1 Mindfulness

Mindfulness is considered to be “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment” (Kabat-Zinn, 2003, p. 145).

Self-care has been proposed as having an inherently mindful quality (Richards et al., 2010). Mindfulness has thus been investigated to ascertain whether it may account for the potential positive effects of self-care; indeed number of studies found mindfulness to mediate the relationship between self-care and psychological wellbeing or burnout. Surveying mindfulness, burnout and preferences for career-sustaining behaviours in 167 Australian psychologists, Di Benedetto and Swadling (2014) found a weak relationship between career-sustaining behaviours and burnout, which decreased after controlling for mindfulness. Similarly, in their study of 148 mental health professionals in America, Richards et al. (2010) found that mindfulness (as measured by the Mindful Attention Awareness Scale; Brown & Ryan, 2003) mediated the relationship between reported self-care importance (participants rated four areas of self-care based on the author’s literature search: physical, spiritual, support and psychological) and wellbeing (as measured by the Schwartz Outcomes Scale-10; Blais et al., 1999). Interestingly, mindfulness was not found to affect the relationship between reported self-care frequency and wellbeing. However, the employment of measures that are not validated to measure self-care limits the conclusions that can be drawn.

Mindfulness has also been investigated as a potential moderator of the relationship between self-care and psychological distress. Slonim, Kienhuis, Di Benedetto, and Reece (2015) surveyed 207 medical students in Australia; mindfulness (as measured by the Five Facet Mindfulness Questionnaire [Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006]) was reported to moderate the

relationship between self-care (as measured by the Health-Promoting Lifestyle Profile II [Walker, Sechrist, & Pender, 1987]) and psychological distress (as measured by the Depression, Anxiety, and Stress Scale [Lovibond & Lovibond, 1995]). However, as the self-care measure focusses on health-promoting behaviours, any conclusions regarding self-care should be drawn with caution. Despite the methodological limitations discussed, the studies suggest that mindfulness may be a key concept in self-care.

1.5.1.2 Self-compassion

It has been suggested that the effects of mindfulness on psychological wellbeing may themselves be mediated by self-compassion (Coleman, Martensen, Scott, & Indelicato, 2016; Yip, Mak, Chio, & Law, 2016). Described as a “key construct within the field of self-care” (Sinclair et al., 2017, p. 168), self-compassion has been defined as relating compassionately towards oneself through the active encouragement of warmth, concern and caring expressed towards the self (Neff, 2003a). Self-compassion was conceptualised by Neff as having three inter-connected elements: self-kindness (as opposed to self-judgement), common humanity (as opposed to isolation), and mindfulness (versus over-identification). Coleman et al. (2016) suggested that a therapist’s self-compassionate stance may influence their beliefs about being deserving of self-care.

Preliminary support for the mediating role of self-compassion in the positive effects of mindfulness was found in a meta-analysis by Gu, Strauss, Bond, and Cavanagh (2015). Building on the results of this meta-analysis, Yip et al. (2016) reorganised the Self-Compassion Scale (Neff, 2003b) into two factors of self-warmth and self-coldness. Using this reorganised measure with a sample of 77 clinical psychologists and trainees in Hong Kong, Yip et al. (2016) found the effect of mindfulness on burnout was mediated by self-coldness, and the effect of mindfulness on compassion to clients was mediated by self-warmth.

However, as mindfulness is considered to be an integral part of self-compassion (Neff, 2003a), it is difficult to draw distinct conclusions about the concepts’ relationships to self-care. Furthermore, self-compassion has been criticised for its lack of specificity and construct validity: following a meta-narrative review,

Sinclair et al. (2017) proposed that self-compassion would be more accurately conceptualised as a composite of self-care, healthy self-attitude, and self-awareness. With this in mind, further research is required to better understand the relationship between mindfulness, self-compassion, and self-care.

1.5.2 Summary

The studies presented in this section together suggest a positive relationship between self-care and psychological wellbeing. However, this conclusion must be drawn tentatively due to the methodological limitations of the studies involved, and the lack of an agreed conceptualisation of self-care in the literature. Mindfulness and self-compassion have both been suggested as key to understanding the proposed benefits of self-care. However, further research is required to better understand the roles of mindfulness and self-compassion in self-care.

1.6 Self-Care as an Imperative

As discussed, there appears to be a positive relationship between self-care and psychological wellbeing. Linking this to the potential effects of psychological distress on therapists' professional functioning (as discussed in section 1.4), a number of publications propose that therapists should proactively engage in self-care in order to safeguard their competence (e.g. Barnett & Cooper, 2009). This section explores the idea of proactive self-care as an imperative for therapists.

1.6.1 Ethical Imperative to Self-Care

Self-care has been proposed as an “ethical imperative” for therapists (Barnett et al., 2007, p. 604); the argument being that should therapists refrain from addressing their own self-care needs, they may not be in a position to care for others. In line with this, self-care is referenced in a number of UK professional ethical guidelines, as detailed below.

The British Psychological Society's (BPS) Code of Ethics and Conduct (2018) mandates the need to “remain alert to signs of impairment”, to be aware of and seek assistance for “problems that may impair their own professional

competence”, and to “refrain from practice when their professional competence is seriously impaired” (p. 17). Self-care is termed as a core competency and ethical requirement in the guidelines of the Health and Care Professionals Council (2016), which regulates therapists working in NHS settings. Similarly, self-care is mandated by the British Association for Counselling Professionals’ Ethical Framework (2016), which emphasises the requirement to “take responsibility for our own wellbeing as essential to sustaining good practice” (Section 75: Care of self as a practitioner), going on to detail the need to maintain physical health and safety, to maintain psychological health, to seek professional support when needed, and to keep a healthy balance between work and other areas of life.

Although the British Association for Counselling Professionals’ Ethical Framework (2016) describes what care of the self may involve, self-care is not clearly defined in any guidelines. As there is also a lack of research into how NHS staff understand or engage in self-care, it is difficult to know what the outworking of these guidelines may look like in practice. It has been suggested that a proactive approach should be taken to self-care, explored further below.

1.6.2 Proactive Self-care to Prevent Impairment

Although the BPS Code of Ethics and Conduct (2018) highlights the need remain alert to signs of impairment, evidence suggests a difficulty in identifying when one is not competent (Dunning, Heath, & Suls, 2004). Indeed, it would appear that the least competent may be the most unable to accurately assess their competence (Kruger & Dunning, 1999). As such, Barnett and Cooper (2009) suggested that one must take a proactive approach to self-care, proposing that it is insufficient for therapists to react when they identify that distress is impacting their competence. Furthermore, it has been proposed that the experience of psychological distress is associated with reduced self-monitoring (Skovholt et al., 2001).

Norcross and Barnett (2008) argued that it is insufficient to act only when professional competence has been compromised, but that therapists must maintain a proactive approach to the care of themselves. Similarly, Wise et al.

(2012) highlighted the importance of engaging in self-care as part of an ongoing commitment to maintain competence.

1.7 Self-Care Recommendations

An argument has been presented for the need for therapists to proactively engage in self-care, as a potential means of improving psychological wellbeing and safeguarding professional competence.

From the literature across helping professions, recommendations around self-care include aspects such as sufficient sleep (e.g. Baker, 2003; Eckstein, 2001); a healthy diet (e.g. Witmer & Young, 1996); exercise (e.g. Shanafelt, Sloan, & Habermann, 2003); writing (e.g. Charles, 2010; Warren et al., 2010); meditation or mindfulness (e.g. Shapiro & Carlson, 2009); supervision (e.g. Baker, 2003; Barnett et al., 2007); work-life balance (e.g. Blust, 2009; Puterbaugh, 2008); personal therapy (Barnett et al., 2007); relationships with others (e.g. Figley, 2002; Witmer & Young, 1996); taking annual leave (e.g. Lawson et al., 2007); spirituality (e.g. Eckstein, 2001); and reflection (e.g. Stebnicki, 2007).

Richards et al. (2010) noted that self-care recommendations have tended to fall into the areas of physical wellbeing, psychological wellbeing, spiritual wellbeing, and support. Similarly, Dorociak et al. (2017) concluded that self-care recommendations often focus on the domains of physical, spiritual, emotional, and social wellbeing.

1.7.1 Critique of Self-Care Recommendations

Criticising the self-care literature for focussing on behaviours, Norcross and Barnett (2008) suggested that the recommendation of particular self-care techniques for all therapists is somewhat futile, due to the vast number of possible techniques and individual differences in preferences and lifestyle. They went on to propose that existing recommendations around self-care are so generalised that, at times, the recommendations can come across as hollow. Instead, Norcross and Barnett suggested adopting principles and strategies which can be adapted for different individuals and circumstances. Such principles were proposed and elucidated by Norcross and Guy (2007). The principles suggested were: 'valuing the person of the psychotherapist';

'refocussing on the rewards of the work'; 'recognising hazards of the work'; 'minding the body'; 'nurturing relationships'; 'setting boundaries'; 'restructuring cognitions'; 'sustaining healthy escapes'; 'creating a flourishing environment'; 'undergoing personal therapy'; 'cultivating spirituality and mission'; and 'fostering creativity and growth'. These principles are thought provoking and potentially useful. However, as recommendations about self-care, they appear to have been developed from clinical experience, without empirical testing.

Miller and Sprang (2017) criticised the literature for an assumed direct causal relationship between compassion and compassion fatigue, and for the suggestion that self-care is a separate activity distinct from work (critiques discussed in sections 1.4.3.1 and 1.3.1). Miller and Sprang instead proposed the Components for Enhancing Clinician Engagement and Reducing Trauma (CE-CERT) Model, a components-based practice and supervision model for reducing compassion fatigue. Although not a model of self-care as such, this model seems an important development in the literature which warrants further discussion. The CE-CERT model is based on the concept that compassion fatigue and burnout can be avoided through ongoing emotional regulation, rather than through recovery in one's own time. The five components of this model, drawn from trauma therapy, are: experiential engagement, regulating rumination, conscious narrative, reducing emotional labour, and parasympathetic recovery. Experiential engagement involves the acknowledging and allowing of all emotions related to therapeutic work.

Regulating rumination is the skill of leaving work at work. Conscious narrative refers to the construction of a narrative of a difficult or traumatic experience which facilitates assimilation, and calming of dysregulation. Reducing emotional labour involves developing the skills required for reducing the perceived burden of the work, such as enhancing genuine empathy and working with difficult feelings. Parasympathetic recovery refers to the use of ongoing strategies to monitor and regulate physical, psychological, and emotional arousal.

Although the CE-CERT model is atheoretical (Miller & Sprang, 2017), the model appears to have some parallels with the principles of ACT, a third wave CBT model. ACT emphasises mindfulness, acceptance, and engagement in valued activities, instead of avoidance of difficult feelings (Hayes et al., 2011). ACT has

also been recommended as a values-based, rather than activity-based, approach to self-care (Dattilio, 2015; Pakenham, 2015; Pakenham & Stafford-Brown, 2013). However, a recent review of ACT-based training in fostering self-care concluded that there is evidence that such training reduces stress and stigmatising attitudes (including towards the self), but found inconsistent results related to burnout, self-compassion and psychological wellbeing (Rudaz, Twohig, Ong, & Levin, 2017).

1.8 Therapists' Engagement in Self-Care: A Summary of Key Studies

Despite numerous publications recommending self-care to therapists, there is less information in the literature about therapists' attitudes towards or engagement in self-care (Dorociak et al., 2017). This section summarises key studies which have examined these topics, before going on to discuss potential barriers to engagement in self-care.

1.8.1 Beliefs About Self-Care

Studies exploring therapists' beliefs about self-care are discussed below. As highlighted by Bloomquist, Wood, Friedmeyer-Trainor, and Kim (2015), there is limited research into this area.

Brownlee (2016) conducted the only published study to date of self-care with therapists in the UK. Conducting thematic analysis on interviews with seven counsellors, Brownlee reported that participants considered self-care to be important but difficult to prioritise due to feelings of guilt and self-indulgence. Although this study may be key in understanding the beliefs about self-care in UK therapists, the generalisability is questionable due to the small sample size. Bloomquist et al. (2015) developed a measure of self-care perceptions for their study exploring self-care with 786 social workers delivering therapeutic interventions in America. Using five-point Likert scales, participants rated eleven items according to their agreement with statements. With mean scores of over four, participants agreed most strongly with 'I value self-care' and 'Self-care is effective in alleviating job-related stress'. Four items received a score of three or more: 'The Masters of Social Work program from which I graduated values self-care'; 'My current employer values self-care'; 'My Masters of Social Work

program taught me how to effectively engage in self-care'; and 'It is easy to engage in self-care practice'. Items scoring less than three related to factors which prevent engagement in self-care (workload, family obligations, community obligations, and social life), and to effective teaching of self-care by their current employer. Although these results are useful in terms of understanding agreement with each of the statements, the variance in the items (for example in asking about individual and employers' value of self-care, as well as barriers to self-care) makes it difficult to draw conclusions from the measure as a whole.

A few studies used the CBSQ to ascertain which behaviours (from a pre-determined list) participants endorsed as important in maintaining their professional functioning. Despite not directly equivalent to attitudes towards self-care, it is interesting to see which behaviours participants value. Lawson and Myers (2011) surveyed 506 members of the American Counseling Association. Out of a possible seven, the following behaviours received a mean rating of six (highly important) or higher: 'spend time with partner/family'; 'maintain sense of humour'; 'maintain balance between professional and personal lives'; 'maintain self-awareness'; 'reflect on positive experiences'; 'engage in quiet leisure activities'; 'try to maintain objectivity about clients'; and 'maintain professional identity'. These results were similar to that of Lawson (2007), who completed the measure with 408 members of the American Counseling Association. In this study, 'maintain sense of control over work responsibilities' also achieved a mean rating of over six, while 'maintain professional identity' did not. Rupert and Kent (2007) obtained similar results in a survey of 595 psychologists in America, with engaging in hobbies also being rated over six. In Lawson's (2007) study, 74% of the behaviours presented were rated as moderately or highly important (rated five or above). In Rupert and Kent's (2007) study 68% received the same rating.

Despite their limitations, these studies together indicate that professionals delivering therapeutic interventions tend to consider self-care as important and effective in managing job-related difficulties. The therapists endorsed a wide range of behaviours.

1.8.2 Engagement in Self-Care

A number of studies have explored therapists' engagement in self-care. These studies are summarised below, some of which comment on the perceived efficacy of reported behaviours.

Alani and Stroink (2015) conducted qualitative interviews about self-care engagement with seven mental health professionals working with survivors of intimate partner violence in Canada. They summarised the reported self-care strategies as: traditional self-care (social support, physical activity, eating well, drinking water, connecting with spirituality, and taking time out); selfless self-care (activities contributing to the community); celebration of strengths (acknowledging strengths, being kind towards self, forgiving self); and continuing training and education.

Harrison and Westwood (2009) conducted interviews with six peer-nominated master therapists in Canada, asking the question 'how do you manage to sustain your personal and professional wellbeing, given the challenges of your work with severely traumatised clients?'. They reported nine salient themes: countering isolation personally, professionally and spiritually; developing mindful self-awareness; consciously expanding perspective to embrace complexity; active optimism; holistic self-care; maintaining clear boundaries; exquisite empathy; professional satisfaction; and creating meaning. In terms of the holistic self-care theme, participants reported attending to physical, mental, emotional, spiritual and aesthetic aspects of wellbeing. Participants also recommended accessing personal therapy, and drawing boundaries between the personal and professional realm.

Killian (2008) interviewed 20 trauma therapists in Texas about stress and coping in their work. Participants spoke about engaging in specific strategies including taking processing time, supervision, quality time with friends and family, exercise, and spirituality.

Exploring job burnout in practitioners working in an eating disorder setting, Warren, Schafer, Crowley, and Olivaria (2012) gave 298 professionals an open-ended questionnaire about what they have done to avoid burnout. Participants included psychotherapists, psychologists, and psychiatrists. Ninety-two percent

of respondents reported engaging in activities that were classified as self-care. These behaviours included: exercise, social support, hobbies and leisure, time off, eating well, relaxation, detaching from work, boundaries/life balance, alone/personal time, sleep, and meditation. Other activities were also undertaken to avoid burnout, but were not classified in the study as self-care, including: professional support, limiting caseload/hours/types of clients, therapy, spirituality/religion, humour, and continuing professional education. The criteria for classification as self-care were unclear.

Coster and Schwebel (1997) interviewed six peer-nominated well-functioning American psychologists about the factors that contribute to their functioning. The study identified ten themes: peer support; stable personal relationships; supervision; a balanced life (i.e. having time for recreation, family and friends); affiliation with a graduate department or school; personal psychotherapy; continuing education; family of origin (as a source of values, identity formation, self-esteem and security); the costs of being impaired (as a motivator to engage in self-care); and coping mechanisms (including time off, rest, relaxation, time with friends, and spirituality). A 29-item measure was created based on these interviews, in which participants (339 psychologists in New Jersey) used a five-point Likert scales rate the extent to which each item contributed to their well-functioning. Items which received a mean rating of over four were: self-awareness/self-monitoring; personal values; preserving balance between personal and professional lives; relationship with spouse/partner/family; and personal therapy.

Engle, Peterson, McMinn, and Taylor-Kemp (2017) presented 108 psychologists in America with a list of 18 coping strategies (drawn from the self-care literature), asking which strategies they had used in the preceding year. The most commonly reported strategies (used by over 90% of respondents) were social activities, exercise, family, friends, colleagues, hobbies, and holidays. Over 80% of those who used such strategies considered them to be somewhat to highly effective.

As highlighted, research about therapists' actual engagement in self-care is somewhat limited, particularly in relation to the amount of recommendations in the literature about self-care. However, particular themes are frequently

reported in both qualitative and quantitative studies, reflected in the facets of self-care reported by Wise and Barnett (2016): physical, emotional, relational, and spiritual wellbeing.

1.8.3 Relationship Between Beliefs and Engagement

Bober and Regehr (2006) noted a dearth of research into whether beliefs about efficacy of self-care translated into actual engagement. They investigated this relationship in 259 trauma therapists in Canada. Bober and Regehr developed a measure for the study, asking participants firstly to rate items in terms of their belief that the behaviour presented would lower levels of vicarious trauma (arising from listening to clients' trauma narratives), and secondly to rate items according to time spent on the behaviour. In order to develop the measure, 330 participants were presented with 27 behaviours drawn from the self-care literature. Following a factor analysis, these were reduced to 13 items within the 'belief' component of the scale (with subscales: leisure, self-care, and supervision), and 17 items within the 'time' component of the scale (subscales: leisure, self-care, supervision, and research and development). The measure was reported to have adequate reliability and validity (Bober, Regehr, & Zhou, 2006).

Results indicated a belief that all strategies presented were helpful in reducing vicarious trauma. However, the study found no significant correlations between beliefs in the benefits of leisure or self-care with the time devoted to such activities. Belief about the efficacy of supervision was significantly positively related to time spent in supervision.

Bloomquist et al. (2015) found similar results. As well as attitudes towards self-care (discussed in section 1.8.1), the study also looked at actual engagement in self-care using measures developed for the study. Despite the statement 'I value self-care' receiving a mean score of 4.5 on a five-point Likert scale of agreement, average reported engagement across all self-care activities was comparatively low (with a mean score of 3.3 on a six-point Likert scale).

The measures used in Bloomquist et al.'s study were not validated. However, together with Bober and Rohegr's (2006) study, these findings indicate that although therapists may believe in the benefits of self-care, this may not result

in self-care engagement. Bober and Rohegr (2006) concluded that a focus on individual's coping strategies individualises problems related to the stress and psychological distress, arguing that more systemic action may need to be taken. It may also be that there are barriers which prevent engagement in self-care. These proposals are explored further in the following section.

1.8.4 Summary

As demonstrated, therapists appear to value self-care, and believe in its efficacy at least in maintaining professional wellbeing. Reported engagement of self-care tends to fit into the facets of self-care proposed by Wise and Barnett (2016) of physical, emotional, relational, and spiritual wellbeing. However, it appears that beliefs about the efficacy of self-care may not result in engagement.

1.9 Barriers to Self-Care

The indication that there is a disparity between beliefs about and time devoted to self-care warrants an exploration of potential barriers to self-care. However, the literature includes remarkably little about such barriers (Alani & Stroink, 2015). Publications which discuss barriers to self-care are summarised below, before an exploration of the role of the workplace in facilitating self-care.

Alani and Stroink's (2015) qualitative study (discussed in section 1.8.2) also investigated barriers to self-care. They reported that participants spoke about other priorities, such as responsibilities at home, that often take precedence over self-care activities. Participants also noted the difficulties in engaging in self-care activities in a mindful way, due to challenge of letting go of stressors.

The measure used to assess perceptions about self-care in Bloomquist et al.'s (2015) study (previously discussed in section 1.8.1) proposed a number of potential barriers to self-care, including workload, family obligations, community obligations, and social life. Mean agreement with each statement (e.g. 'My workload prevents me from engaging in self-care') was rated as less than three on a five-point Likert scale, indicating that participants did not consider these to have a strong effect on their self-care engagement. However, as this measure

was not empirically validated, and was not developed to assess barriers to self-care, these conclusions must be drawn tentatively.

Bettney (2017) reflected personally about barriers to self-care from the perspective of a newly qualified clinical psychologist in the UK. She highlighted personal, professional and systemic barriers. In terms of personal barriers, Bettney noted individual tendencies may inhibit self-care engagement, such as perfectionistic attitudes and a difficulty accepting help from others. Bettney argued that these are common to those in helping professions, and exacerbated by applying to Clinical Psychology training. In terms of professional barriers, Bettney highlighted the multiple demands placed on trainee and qualified psychologists. As emphasised by Pakenham and Stafford-Brown (2012), training courses tend to encourage self-care, but course demands leave little time for self-care. Bettney (2017) also reflected on systemic barriers to self-care, highlighting the wider social and political system in which the NHS is placed. Bettney suggested that the increasing pressures placed on NHS clinicians inhibit self-care.

Bettney's reflections were similar to the findings of Brownlee's (2016) study. As well as exploring perceptions of self-care (previously discussed in section 1.8.1), participants also spoke about barriers to self-care. In the analysis, Brownlee categorised such barriers into internal and external factors. Internal factors concerned tendencies and attitudes. External factors related to demands on their time, and the money needed to engage in self-care.

Discussing how to address the barriers to self-care, Bettney (2017) concluded that self-care needs to be prioritised on therapeutic training courses. This reflects a number of authors' concerns that self-care may not be sufficiently addressed in therapy training or continuing professional development (Pakenham & Stafford-Brown, 2012; Walsh & Cormack, 1994; Wise et al., 2012). Bettney (2017) also highlighted the need for systemic change in the approach to staff wellbeing and self-care in organisations such as the NHS.

1.9.1 Self-Care: An Individual's Responsibility?

Systemic and organisational pressures have been suggested as barriers to self-care (Bettney, 2017). Discussing responsibility for self-care and wellbeing,

Pakenham (2015) emphasised that self-care cannot be considered solely the responsibility of the individual. Pakenham suggested that this approach may inadvertently blame individuals for experiencing psychological distress, and allow for the continual increase of unattainable working demands, an argument echoing that of Bober and Rohegr (2006). Grawitch, Ballard, and Erb (2015) noted that workplaces often implement stress management efforts at an individual level, whilst retaining organisational practices which may have led to the stress in the first place.

Huggard (2003) stressed the need for organisations to develop respect and care for staff in the same way that the staff provides compassionate care for those using the services. He argued that this would support staff in their self-care and help sustain the compassionate care staff provide; a key concern raised by the Francis Report (2013). Barnett and Cooper (2009) suggested that it should be considered a responsibility of both the individual and the profession to create a culture of self-care. However, given the lack of research into NHS therapists' understanding of or engagement in self-care, it is difficult to draw conclusions about the impact of the NHS context on staff self-care

1.10 Rationale for Current Study

A review of the literature suggests that research into self-care has been hampered by a lack of clarity around the concept. As a result, the ability to make recommendations around this topic is also limited, despite the references to self-care in ethics codes, and the many publications which propose the use of specific techniques of self-care.

Further research about self-care of therapists is required, particularly as psychological distress reported by therapists appears to be increasing, most notably amongst those working in the NHS (Rao et al., 2017). As highlighted by Pakenham (2015), simply providing therapists with information on self-care strategies is not likely to be sufficient; therapists are highly trained and are typically aware of what is needed to maintain psychological wellbeing.

The disparity between the reported value placed on self-care, but low engagement in self-care (Bloomquist et al., 2015; Bober & Regehr, 2006) is particularly notable. In order to understand this further, a deeper understanding

is required about what self-care means to therapists in principle and practice, as well as a better understanding of the factors that facilitate and hinder self-care.

Furthermore, to date there has only been one published study about therapist self-care conducted in the UK. As a result of the current context of the NHS and statistics on staff psychological wellbeing within the NHS (Rao et al., 2017), it appears important to study self-care from the point of view of NHS professionals.

This study seeks to address the highlighted limitations of the current literature base by furthering the existing understanding of what self-care means to NHS therapists in both principle and practice, and exploring what factors facilitate and hinder engagement in self-care. The dissemination of this information could support therapists to develop their own self-care practice.

1.10.1 Research Questions

- How do NHS psychologists and high intensity therapists describe their understanding of self-care?
- How do NHS psychologists and high intensity therapists describe their engagement in self-care?
- How do NHS psychologists and high intensity therapists describe their views on what facilitates self-care?
- How do NHS psychologists and high intensity therapists describe their views on what hinders self-care?

2. METHODOLOGY AND METHOD

This chapter describes the methodology and method of the study. The epistemological position and rationale for the study's approach are presented, and the processes of data gathering and analysis outlined. Research reflexivity and evaluation are also discussed.

2.1 Epistemological and Ontological Position

Epistemology is the philosophy of knowledge: consideration of the extent to which the 'real world' can be known, and the extent to which knowledge is reliable and valid (Willig, 2012). In order to produce coherent research, the epistemological position of the research must be clarified, and the adopted method and methodology must be consistent with this stance (Harper, 2012). In establishing an epistemological stance, an ontological position must also be considered: the extent to which the 'real world' exists outside of interpretation of it (Harper, 2012). Ontological positions can be realist, in which the real world consists of structures and cause-effect relationships, or relativist, where there is no objective truth about the world (Willig, 2013).

This research took a critical realist epistemological stance. Critical realism provides a middle ground between naive realism, which holds that truth about the real world exists and can be accessed, and extreme relativism, which proposes that all knowledge is constructed (Willig, 2013). Ontologically, critical realism takes a realist stance, holding that there are entities that exist independently of their identification, as not all are constructed from discourse (Willig, 2013). However, a critical realist epistemology maintains that although entities and concepts may exist, knowledge and knowledge production are subjective, derived from a person's personal and wider social, political and historical context (Bhaskar, 1989). Thus, although research may seek to gain an understanding of the 'real world', this information is not directly available. The world can only be accessed indirectly via observation, with the research processes influenced by fallibility of observation, human error, and biases (Trochim, 2000).

In adopting a critical realist stance, this study operated on the understanding that material reality will influence how the concept of self-care is understood. Participants are likely to take different perspectives on self-care, informed by their own experience. As such, the data produced cannot be considered to be a direct reflection of an underlying 'true' concept (Willig, 2013).

2.2 Qualitative Methodology

Qualitative research typically explores the meaning, texture, and quality of experiences (Willig, 2013). Qualitative methodologies enable participants to respond to questions in their own language, drawing on their own understanding and experiences (Willig, 2003). These methodologies are particularly useful in research that seeks to deepen knowledge, rather than testing out existing hypotheses, as the approach facilitates discovery and exploration (Braun & Clarke, 2012). As the topic of therapist self-care is not well defined or understood, I concluded that a qualitative methodology was most appropriate for this study.

2.2.1 Choice of Approach

I selected thematic analysis (TA) as the most appropriate qualitative method for the study. However, before this decision was made, I considered a number of possible alternatives, including interpretative phenomenological analysis (IPA), grounded theory, and discourse analysis. Each of these methods are discussed below, followed by a rationale for my choice of TA

IPA aims to "explore in detail how participants are making sense of their personal and social world" (Smith & Osborn, 2007, p. 54), and carefully considers the nature of the interaction between the participants and researcher (Willig, 2013). This study sought to gain an understanding of how participants made sense of the concept and practice of self-care, however I felt that the research questions required exploration of more than the participants' subjective experience. This was also supported by the focus of the research questions, which did not encompass the relationship between the researcher and participants. Furthermore, IPA requires a homogenous sample (Smith & Osborn, 2007), whereas this study aimed to recruit as diverse a group as

possible (for example, in qualification, gender, ethnicity, length of time since qualification, and type of service worked in). For these reasons, I felt that IPA was not the most appropriate method to adopt.

Grounded theory (Glaser, Strauss, & Struzel, 1968) was also considered as a possible method. Grounded theory is typically used to develop new theories grounded in the data produced (Green & Thorogood, 2010). This study sought to take a more exploratory approach, however, looking at how participants understand and engage in self-care; I did not have an intention to produce a new theory or model. Willig (2013) argued that although grounded theory can be used in such an exploratory manner, this is more appropriate for research into social processes. As such, I deemed that grounded theory was not an appropriate method for this research.

I also considered discourse analysis, which investigates how reality is constructed through language (Willig, 2013). However, the use of discourse analysis would not have enabled the research questions to be answered. This is because the research questions focus on participants' understanding of and engagement in self-care, rather than how participants construct reality through the way they talk about self-care. Furthermore, discourse analysis requires a more social constructionist epistemological stance, and is most appropriate for naturally occurring language (Potter & Hepburn, 2005). Therefore, I did not feel that discourse analysis was an appropriate method for this study.

TA is a qualitative method that aims to systematically identify and analyse patterns of meaning across data (Braun & Clarke, 2006). By organising and describing these patterns in rich detail, TA can be used to make sense of shared meanings and experiences (Braun & Clarke, 2012). In contrast to other qualitative methods, TA offers a method of data analysis, rather than an approach to conducting research (Braun & Clarke, 2012). This flexibility allows TA to be suited to a range of theoretical and epistemological stances, including critical realist (Joffe, 2012), however it is therefore imperative that the epistemological position of the research is explicitly identified. The method can be used across studies which may vary according to research interests, data type, and amount of data (Clarke & Braun, 2013). Because of these reasons, I concluded that TA was the most appropriate method for this research.

2.2.1.1 Thematic analysis

I chose to use Braun and Clarke's (2006) guidelines to guide the application of TA in this study, as these guidelines have been described as both systematic and sophisticated (Howitt & Cramer, 2007). This decision was also based on the suggestion that in comparison to Braun and Clarke's (2006) guidelines, TA based on alternative guidelines may not offer the extent of epistemological flexibility, and may be more suited to more realist or post-positivist stances (Braun & Clarke, 2014).

Coding and theme identification in TA can take a more inductive or deductive approach. An inductive approach involves identifying themes strongly linked to the data, without seeking to fit the data into preconceived coding frames. A deductive approach involves analysing the data through the lens of pre-established areas of interest (Braun & Clarke, 2013). In practice, it is not possible to adopt a purely deductive or inductive approach (Braun & Clarke, 2013): the study must be grounded in the data itself, yet will naturally be influenced by research interests and completion the literature review. I thus adopted a combined inductive and deductive approach, with an emphasis on the inductive. This decision was made due to the lack of clarity in the literature around the topic of self-care which indicated that it may not be prudent to apply a preexisting frame or expected direction to the data.

An additional consideration for TA is the level at which themes are identified. TA can privilege themes at the manifest or latent level (Braun & Clarke, 2013). Manifest themes report the more direct, and often more 'obvious', observations from the data; TA at the latent level seeks to explore the ideas and assumptions behind what is said explicitly (Braun & Clarke, 2006). This study aimed to draw out both manifest and latent themes. Joffe (2012) advocated for this combined approach, suggesting that high quality research takes an inductive-deductive approach to both latent and manifest themes.

TA has been criticised for its potential to decontextualise data, and to underplay the role of the researcher in the interactions of the focus groups or interviews (Mishler 1986). In order to avoid the potential for such decontextualisation, I adopted a 'contextualist' method (Braun & Clarke, 2006). This acknowledges

that social context will influence the way that individuals make sense of their experiences, but retains a focus on the material. In addition to this, I kept a research journal throughout the study, which helped me to be more aware of my own influence on the data collection, analysis and interpretation (Ortlipp, 2008). This is discussed further in section 2.7, and excerpts from the journal are shown in Appendix A.

2.2.2 Focus Groups

I felt that the use of focus groups, rather than individual interviews, would be most suited to the aims of this research. Focus groups have been proposed as optimal for providing insights into understandings of concepts, behaviours and motivations, due to the opportunities available to participants to query and explain themselves to one another (Morgan & Krueger, 1993). The group discussion of a concept also allows the researcher to ascertain the extent of consensus, where participants' agreement and disagreement with one another is likely to be more explicit, and participants can be asked for comparisons of their experiences and views (Morgan & Krueger, 1993). Due to the lack of consensus about the concept of self-care in the literature, I felt that group discussion of self-care would therefore be the most appropriate means to gather data.

2.3 Ethical Considerations

Careful consideration was given to gaining ethical approval, informed consent, and data security, as detailed below.

2.3.1 Ethical Approval

I initially sought ethical approval from the University of East London (UEL), however it became apparent that it would be necessary to seek ethical approval from the Health Research Authority (HRA), as participants would be recruited through their role within the NHS. The application for UEL ethical approval is shown in Appendix B. Confirmation of ethical approval from both UEL and the HRA are shown in Appendices C and D, although ultimately it was HRA approval that was necessary for the study to proceed. A requested amendment

was later approved by the HRA to add a third Trust as a research site, as the initial application only covered two Trusts (shown in Appendix E). Once HRA ethical approval was granted, confirmation of capacity and capability was requested from and given by each of the Research and Development (R&D) departments of each of the Trusts from which participants were recruited (shown in Appendix F).

2.3.2 Informed Consent and Debrief

Potential participants were provided with information about the study through the information sheet (shown in Appendix G) via email. Those who elected to take part were given an additional copy of the information sheet at the beginning of each focus group, and were invited to raise any concerns or questions they had about the study. Participants were also reminded that they were free to withdraw or take a break from the discussion at any time. Before the discussion began, I asked participants to sign a consent form (shown in Appendix H). Following the focus group, I gave participants a debrief sheet (shown in Appendix I), which advised speaking to their supervisor, line manager or Occupational Health department if they had concerns about their wellbeing or self-care. Participants were also informed of their right to withdraw their data for two weeks following the focus group.

2.3.3 Data Security

Focus group data was anonymised and kept on a password protected computer and in a password protected file. I transcribed the audio-recordings, and all identifying references were changed. I will delete the recordings following examination, and delete the transcripts three years after completion of the study. Participants were made aware of the above information, and were also informed that my supervisors and examiners may have access to the anonymised transcripts.

2.4 Data Collection

Details of the recruitment processes, participants, interview schedule, and practicalities of the focus groups are discussed below.

2.4.1 Recruitment

Once recruitment had been approved by the Trusts' R&D departments, I approached services known to me about the study. Permission was sought from the service manager to email information about the study to psychologists and high intensity therapists within the service. A convenient time for the focus group was arranged with those who expressed interest in taking part.

The inclusion criteria specified that participants must be currently working as a qualified clinical psychologist, counselling psychologist, or high intensity therapist in an NHS setting.

2.4.2 Focus Groups

Determining a sample size for qualitative research is a complex decision, as power calculations are not of use (Willig, 2013). Investigating the number of focus groups needed to identify themes in thematic analysis, Guest, Namey, and McKenna (2016) conducted 40 focus groups on health-seeking behaviours of African American men, and found that 80% of the final themes were present in two to three focus groups, and 90% present in four to six groups. As a result of this, and the time constraints inherent to this study, I decided to conduct four focus groups. This is also in line with Krueger's (1994) suggestion that three or four focus groups are usually sufficient for more 'simple' research, such as a thesis. Considering the numbers of participants, I aimed to have between four and eight participants in each focus group, as per Krueger and Casey's (2000) suggestion that this should provide a sufficient range of perspectives whilst retaining a manageable group. Due to challenges arranging a convenient time for all potential participants, each focus group took place with four participants.

Thus, four focus groups were conducted, each with four participants, giving a total of 16 participants. Three focus groups took place in London, and one in the Midlands. Focus groups took place on NHS premises, in a private room and during working hours. I intended for the focus groups to last between 60 and 90 minutes, in line with recommendations from Litosseliti (2003). However, due to the time constraints of the participants, the length of the groups ranged from 47 to 64 minutes.

2.4.3 Participants

Participants filled in a demographics form before focus groups began (shown in Appendix J). Thirteen participants were qualified as clinical psychologists, one was a counselling psychologist, and two were high intensity therapists (both high intensity therapists were also qualified as counsellors). Participants were recruited from two NHS Trusts in London and one in the Midlands. They worked in a range of settings: adult secondary care, child and adolescent mental health, physical health, inpatient, looked after children, older adults, adults with learning disabilities, and adult primary care. Self-reported information about participants' ethnicity, age, gender, and length of time qualified is presented below in Table 1, along with their assigned pseudonym, and focus group.

Table 1. Participant characteristics

Focus Group	Pseudonym	Ethnicity	Age	Gender	Years Qualified
One	Louise	White British	46	Female	19
One	Catherine	White British	48	Female	20
One	Harry	White Mixed	49	Male	10
One	Tanja	White Other	40	Female	1
Two	April	Irish/English	56	Female	12
Two	Yasmin	Mixed	47	Female	15
Two	Emma	White British	30	Female	2
Two	Jen	White British	33	Female	5
Three	Ed	White British	46	Male	13
Three	Sue	White British	51	Female	9
Three	Alice	White British	42	Female	5
Three	Mia	White European	35	Female	4
Four	Eva	Greek	31	Female	2
Four	Zoe	Irish	44	Female	20
Four	Rob	White British	47	Male	21
Four	Sam	White British	46	Male	11

2.4.4 Interview Schedule

I developed an interview schedule from the research questions and the literature around self-care; the research questions were used as the basis of the interview schedule, with additional questions and prompts to stimulate discussion. This interview schedule was piloted with a group of four trainee clinical psychologists. Their feedback led to the re-ordering of questions, to the provision of time at the end of the focus group to explore participants' reflections on the discussion, and highlighted the need to ensure that I kept questions and prompts short. The final interview schedule is shown in Appendix K.

2.5 Data Analysis

The data were transcribed, and analysed according to recommendations made by Braun and Clarke (2006). This process is detailed below.

2.5.1 Transcription

I conducted and transcribed the focus groups, which helped me to develop initial familiarity with the data (Wilkson, 2008). I used an orthographical style of transcription, as recommended for thematic analysis (Braun & Clarke, 2012). This meant that spoken words were captured, as well as sounds, utterances and pauses.

2.5.2 Analysis

As discussed in section 2.2.1.1, Braun and Clarke's (2006) six-phase approach to thematic analysis was used as the guidelines for data analysis. The six phases are as follows:

2.5.2.1 Phase 1: Familiarising yourself with the data

Once all data was collected and transcribed, I began to 'immerse' myself in the data by reading the material multiple times and listening to the recordings. During this process, I made notes of thoughts and initial observations about topics of interest and possible ideas of themes. Examples of such notes are shown in Appendix L.

2.5.2.2 Phase 2: Generating initial codes

Codes are “the most basic segment, or element, of raw data or information that can be assessed in a meaningful way” (Boyatzis, 1998, p. 63). In order to generate codes, I read the data again carefully, identifying codes for any potentially relevant segment of data. To ensure minimal loss of context, some data surrounding each segment was retained, such as the preceding or following sentence. A coded transcript extract is shown in Appendix M.

As the coding process progressed, I modified and collapsed the codes, noting any similarities, differences and inconsistencies between the codes. Codes were a mix of both descriptive and interpretive (Braun & Clarke, 2006), and in some instances the same data was assigned multiple codes. NVivo 10 for Mac OS was used to collate codes and the associated data. In total, 129 codes were collated, shown in Appendix N. Examples of three codes with associated extracts are shown in Appendix O.

2.5.2.3 Phase 3: Searching for themes

I generated initial themes and subthemes by clustering codes sharing a unifying feature. These were reorganised multiple times, giving consideration to the relationship between themes, and how the themes come together to provide a unifying framework for the overall dataset (Braun & Clarke, 2012). A preliminary thematic map (see Appendix P) was drawn to provide a visual representation of the themes and their relationships to one another at this point. Reviewing these themes with my supervisor, we felt that they were too categorical and directly reflective of the research questions, common mistakes for researchers new to qualitative research (Braun & Clarke, 2013). As a result, I returned to the transcripts, reviewed the codes, and generated a new set of themes, shown in the second preliminary thematic map (shown in Appendix Q).

2.5.2.4 Phase 4: Reviewing potential themes

My supervisor and I reviewed the new potential themes. Through discussion of the themes and the original data (Patton, 1990), we again concluded that the themes did not seem to accurately reflect the dataset or tell a coherent narrative. As TA is an interactive process, I returned to phases 1-3, immersing myself further in the data (Braun & Clarke, 2006). This resulted in the creation

of new themes with a more coherent narrative. These better reflected the original data and were relevant to the research questions. These themes were reviewed for distinctiveness, while the codes and extracts were reviewed for congruity; this was to ensure heterogeneity of themes and homogeneity of codes, as recommended by Patton (1990). This process resulted in three main themes, with three, four, and three subthemes respectively.

2.5.2.5 Phase 5: Defining and naming themes

Themes, subthemes, and the associated codes and extracts were re-read to give consideration to each theme's 'essence'; themes were given an informative and concise name (Braun & Clarke, 2012). Once the themes had been named, I drew a final thematic map, shown below in Appendix R. For each theme and subtheme, I identified extracts which illustrated the analytic point being made.

2.5.2.6 Phase 6: Producing the report

A report is given in chapter 3, where themes are presented and elucidated with associated extracts. By supporting the themes with extracts from across the dataset, the reader is able to judge whether the story being told about the data is based on the data itself. As recommended by Braun and Clarke (2006), I also gave consideration to the order that themes and subthemes were presented, ensuring a coherent narrative throughout.

2.6 Reflexivity

It has been suggested that researchers should seek to adopt an objective stance towards their research, in order to prevent their own influence on the research process (Seale, 1999). However, Spencer, Richie, Lewis, and Dillon (2012) suggested that this may not be possible in practice, particularly when undertaking qualitative research. The researcher plays a central role in the way that data is collated and construed, so cannot be an 'objective observer' (Stratton, 1997).

As such, my own values and assumptions will have influenced the interpretation of the data and the narrative presented. In order to identify and minimise my own influence on the research, a reflexive stance was taken. This involved returning frequently to original transcripts throughout the research process, and keeping a research journal (Ortlipp, 2008). In the journal, I reflected on my own

thoughts, feelings and observations related to the work, particularly noticing strong reactions I had to data, events, and the process of undertaking research. I also noted how my own attitudes towards, and practice of, self-care fluctuated over the course of the study. Extracts from the research journal can be seen in Appendix A, and a reflexive review of the research is presented in section 4.5. The inclusion of these allows the reader to take my own stance into account when drawing conclusions from my analysis of the data

2.7 Evaluation

The evaluation criteria often applied to quantitative research of objectivity, reliability and validity, are rarely a 'good fit' when evaluating qualitative research (Spencer et al., 2003). These criteria are grounded in positivist epistemology, so therefore cannot be used to judge research based on a differing epistemological standpoint (Northcote, 2012). However, although qualitative research cannot be evaluated with the same criteria as quantitative research, the quality must still be assessed (Willig, 2013).

Northcote (2012) completed a review of the 'guiding principles and criteria' commonly used to evaluate qualitative methods and findings, concluding that there is no consensus on a set of standards against which qualitative research should be judged. As a consequence, Northcote (2012) proposed five guiding principles and criteria as an "interconnected overview" (p. 105) of the literature around evaluating qualitative research. These five principles are: contributory, rigorous, defensible, credible, and affective. I chose these principles as a basis because of their grounding in the qualitative literature base. I held the principles in mind throughout the completion of the study, sometimes drawing on them in my research journal reflections. A critical evaluation of the current study, based on Northcote's (2012) principles is presented in section 4.4.1.

3. ANALYSIS

Using three themes and associated subthemes, this chapter presents participants' discussion of self-care. A thematic map is shown in Figure 1 to give an overview of the themes and subthemes. Each theme is expanded on below, with support provided by extracts from transcripts. Minor changes have been made to some quoted extracts for readability, such as removing repeated words and hesitations (such as "umm"). The use of three dots ("...") indicates that words have been removed from the extract.

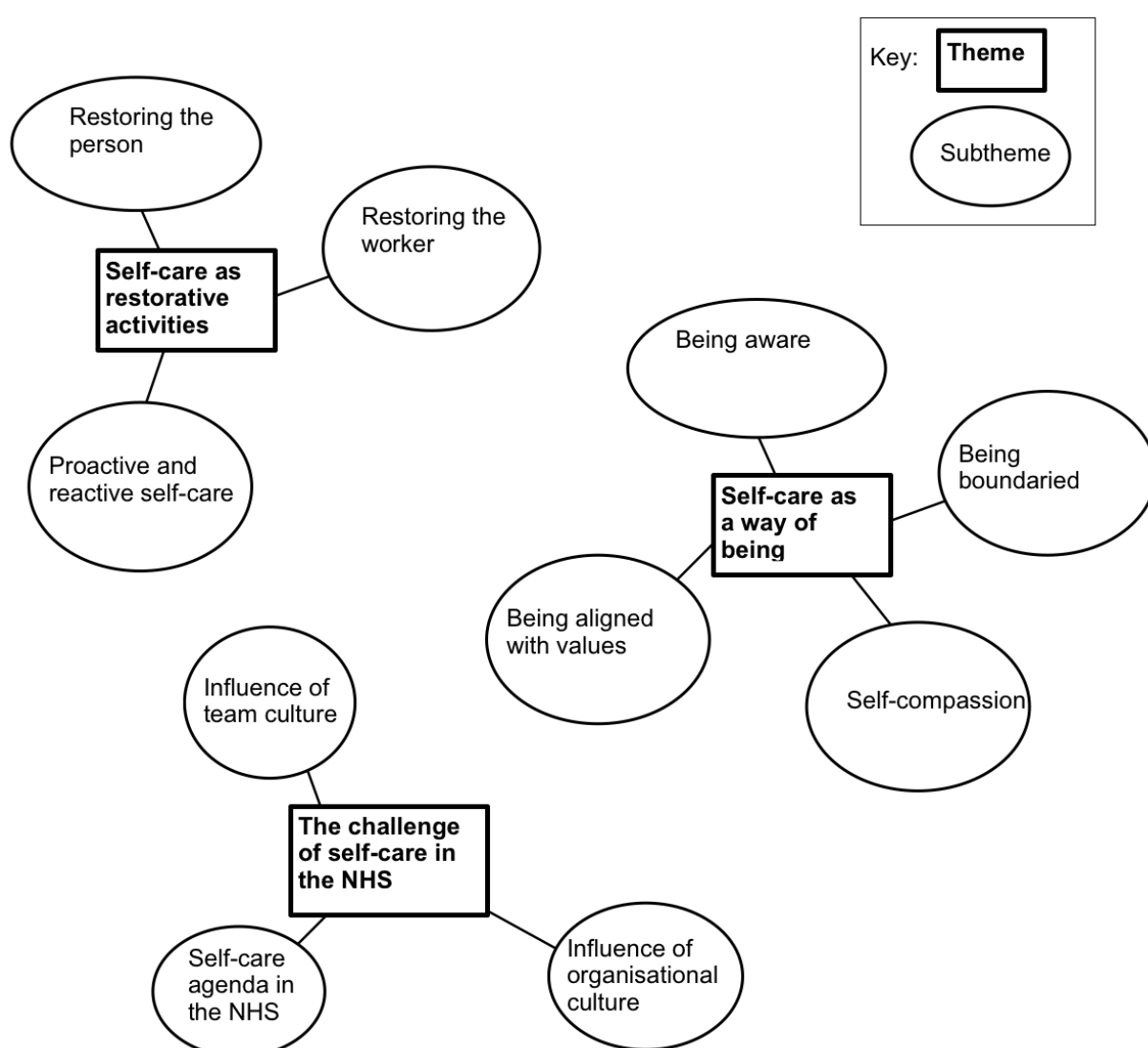


Figure 1. Final thematic map

3.1 Self-care as Restorative Activities

This theme highlights how participants spoke of self-care as discrete activities used to find a sense of balance or restoration when they were feeling depleted. Participants stressed the depleting effects of therapeutic work, asserting the need for self-care to offset these effects. As well as engaging in self-care in order to sustain themselves as a person, participants spoke about engaging in self-care as a means to sustain themselves as a worker, exploring this as a professional responsibility. Participants discussed their approach to engaging in self-care activities; some spoke of being proactive about self-care, while others took a reactive approach.

3.1.1 Restoring the Person

Participants spoke of the importance of the wellbeing of all of themselves:

Sue: Keeping ourselves well and I mean mentally, physically, emotionally, socially, the whole lot, I think is really vital.

In discussing their use of self-care to keep themselves well, different participants spoke about a range of different “self-care activities” (Tanja), including numerous types of exercise (Harry, Sam, Sue), reading (Catherine), personal therapy (Yasmin), spending time with others (Emma), and spending time in nature (Tanja). In speaking about self-care in this way, there appears to be an implication that one is either discretely ‘doing’ or ‘not doing’ self-care; self-care is discrete activities.

Participants spoke about how such activities restore their wellbeing, often drawing on analogies to illustrate this point. The concept of “keeping your balance” (Eva) was common; “feeling recharged” (Harry) as a result of self-care was also mentioned. This language implies that the participants felt that they used particular activities to counteract stressors which negatively impacted their wellbeing. Another analogy, using fuel, further illustrates this point:

Tanja: In our work we give a lot, so I think it’s about making sure that we’re nurturing ourself, or give ourselves something back so that we don’t run out of fuel.

Participants often spoke about how their work as a therapist had an impact on them. I did not directly ask participants about *why* they needed to engage in such activities; despite this, self-care was spoken about in a way that emphasised how it can offset the effects that therapeutic work can have on their psychological wellbeing. This included the effects of hearing about other people's trauma, as well as the "heady" (Yasmin), "hyper-focussed" (Tanja), "draining" (Sam), and "all-consuming" (Sam) nature of the job. There seemed to be an assumed agreement about the efficacy of self-care in managing these effects:

Jen: Sometimes it does feel like a big relief to get out the door at five o'clock, and ... something I started doing about six months ago was to walk to work instead of taking public transport. And I've found, I often know on days when I've had quite a lot of stress at work because I'll feel so glad to have that walk home and to just be somewhere completely different.

April: Some of the things I have to do more consciously are harder to do when I'm in that frame of mind [feeling stressed]. So I know that I should go and do something practical, physical. Those are the things that I need to do sometimes when the stress level has got much greater, and I know that I need to do something to get out of that headspace.

Participants particularly noted how their job could affect their mood or outlook, leaving them feeling "overtaken by [the work]" (Emma). Emma mentioned "a tendency, with the accumulation of everyone else's trauma, to just start having the feeling that the world is this terrible and irredeemable place". Jen similarly spoke about noticing how her work can affect her wellbeing, and the conscious efforts she makes to use self-care to offset this:

Emma: Sometimes when I've noticed only looking back, when my behaviour has changed over a week or so, and I think *ooh, yeah the work is really getting to me this week, what am I going to do about it next week to make sure that this isn't it*. I don't want my life to be like that. I don't want the job to start consuming the bits of my life outside of the job.

A possible underlying similarity about the nature of the self-care activities was explored by a few participants, who spoke about how the activity needed to be “a very different kind of task” to their work (Louise). Catherine went on to consider that it is the lack of responsibility in such activities that makes a difference for her:

Catherine: I like watching things on television that might be very related to the job, or I read books about people’s experiences that are very similar to what I might hear from my clients, but what I find different about that is that ... I might think about it, but I don’t have to take any responsibility for changing anything. And to me, that is different. So even though on the surface it looks like it’s not that different, actually my role in it is very different.

As illustrated by these extracts, participants spoke about self-care in terms of activities that restore their wellbeing. They drew on a number of analogies to illustrate the restorative effect of self-care, and spoke about self-care as a way to offset the depleting effects of therapeutic work. A range of activities were highlighted as self-care engaged in by participants.

3.1.2 Restoring the Worker

As well as discussing how self-care sustains and restores them as a person, participants spoke about self-care sustaining and restoring them as a worker. This subtheme highlights the sense of responsibility participants felt in ensuring that they are able to do their job effectively, and the use of self-care to facilitate that. Harry emphasised that, as therapists, we each have a “responsibility for looking after oneself”.

Again, participants drew on analogies to illustrate how they understood self-care as a means to sustain their ability to work. Rob provided an example:

Rob: One of my first supervisors ... gave me the idea of thermometers, one with resources and one with demands, and looking whether they’re balanced. And I kind of think about that myself sometimes, in the way I’m working: in terms of demands, all the things I need to do that I haven’t done, and what gives me resources, for me hobbies, interests are really

important, and time with friends and family as well, to keep me enthused and yeah, to give me the energy to work.

In this extract, self-care activities appear to be implied as the means to increase the 'resources thermometer'. Once again, this analogy draws on the concept of balance. This indicates that self-care is being understood as a means to provide restoration, with Rob giving examples of particular activities that he finds restorative. Interestingly, Rob's emphasis here is on the activities that restore his ability to work, rather than his personal wellbeing. There is a similar emphasis in the following extract, where Sue is drawing on formulation practices she uses with clients:

Sue: If we were using a car formulation ... of being a psychologist that's mentally and physically capable of doing the job they need to do. So in order for that to be sustained, then we look at background history, who supports you, where your talents lie, and so on. And, there's a whole person, you then look at what enables you to do that job.

Although formulating self-care as a whole, there is an emphasis in this extract about self-care enabling someone to do their job, rather than for the sake of their own psychological wellbeing. The way that participants spoke about self-care as restorative to them as workers implied a sense of responsibility that went beyond managing their own wellbeing. Sue illustrated that for her, self-care is not just about herself:

Sue: I don't believe self-care is just about an individual. It's like the pebble in the pond isn't it. Whatever you do, it ripples to the edge of the pond and back.

Indeed, participants indicated feeling that their own self-care would affect the service they provided to clients. Although no one explicitly spoke about an ethical imperative to self-care, the way participants spoke hints at this. For example, the following comment from Harry mirrors the way that self-care is referenced as part of professional ethical standards (e.g. BPS, 2018):

Harry: It is a responsibility to be, professionally, a clinician that's in a place where you have the capacity to offer something.

This illustrates the responsibility the participants feel to their clients: ensuring that they, as a therapist, are in a position to “give the person what they need” (Sue).

3.1.3 Proactive and Reactive Self-Care

In discussing how they engage in self-care activities, different participants spoke about taking different approaches. Some spoke about being “proactive” (Sue), while others noticed that they adopt a more “reactive” (Ed) approach to their self-care.

Illustrating how they adopt a proactive approach to self-care, some participants spoke of a need to self-care, which motivated them to arrange self-caring activities:

Emma: I need to cram a lot of self-care into the weekend to manage Monday coming around again really soon.

Yasmin: I feel like I’m the sort of person who does do self-care quite a lot anyway, cus I think the job does definitely impact me a lot, and I know it does, so I know I need to.

A number of participants noted that “planning [self-care activities] is something that helps” (Rob) them:

Tanja: I would say I’m often consciously aware of needing to self-care... I’m aware of needing to make a conscious effort ... because getting away to self-care activities involves a lot of planning.

Plans to engage in self-care activities were sometimes contrasted with the temptation of doing something else, implying that the other activities would not be as good for them in the longer term. A number of participants spoke about plans to exercise or meet friends instead of watching television, as illustrated by Jen:

Jen: I probably am much more focussed on making sure that I have lots of things booked in, and that I do a lot of socialising, cus, certainly after quite a heavy day of therapy work, it can be quite tempting just to go home and sit on the sofa and watch tv.

Other participants indicated that they have an intentional routine, which helps to maintain their engagement in self-care activities.

Sue: I've made a kind of very conscious decision to have a routine that keeps some of those things [self-care] in place. ... Getting a rhythm of walking the dog and pilates class once a week, that kind of thing, as part of the getting the work-life balance right.

Sam: It's easy just to flop isn't it, so I think for me routine is quite important. You know, I do like to run, and I sort of recognise that I have to, I slip out of it if I don't keep to a routine, and it takes a bit of an effort to get out of the door. But actually I appreciate it when I go.

In contrast, some other participants spoke about a reactive approach to their self-care:

Ed: I often don't take time to think about it [self-care]. It's almost something I turn to when I'm stressed, rather than proactively doing things.

These participants spoke about having a "boom and bust" (Alice) self-care cycle, where they would reactively turn to self-care activities when they were feeling stressed:

Ed: I find myself thinking that actually what sounds like self-care for a lot of us, is almost a reactive type thing. We get to a point where we think: *I'm going to do that because I'm feeling really stressed*, rather than being a sort of proactive type thing. ... I don't think I just have an idea about proactively managing self-care, if that makes sense.

The way these participants spoke about this self-care cycle indicated that they might like their approach to self-care to be more proactive. Alice described her feelings towards engaging in a reactive self-care cycle:

Alice: I go *Oh, I'm exhausted, I need to take time off, or I need to this, I need to do that*. [Then] I feel better again, crash back into it again! I just think *Oh no! Not again!*

Indeed, reflecting on the discussions, a few participants commented that the group had been a "useful reminder" (Jen) to think about their self-care more.

Some indicated a desire to think more intentionally about their self-care going forward:

Mia: I will definitely think about it [self-care] more. I think it's important to plan for it.

Ed: There's something for me that I'm going to take away from this conversation, really, is that I often don't take time to think about it [self-care]. ... I think it would be better to sort of perhaps be more conscious about what I'm going to do with my time today. Even if it's just a daily or weekly or, you know, just to build in some of these things that do give you a break.

3.2 Self-care as a Way of Being

In addition to speaking about self-care as restorative activities, participants also spoke in ways that indicated an understanding of self-care as a way of being. In discussing self-care in this way, participants indicated that they understood self-care to include being aware of one's wellbeing, needs, and capacity, as well as setting boundaries with their time and with others. Participants spoke about self-care as living according to one's values, and thoughtfully discussed the relationship between self-care and self-compassion.

Throughout these discussions, self-care was spoken about in a way that emphasised its ongoing, and sometimes unconscious, nature. This indicates an additional understanding of self-care to the first theme's emphasis on discrete activities which participants anticipated would have restorative effects. Of note, the same participants spoke about self-care as both a way of being and as discrete restorative activities. This indicates that participants understood self-care to be complex, where self-care could be both a way to 'be' and activities to 'do'.

3.2.1 Being Aware

Participants spoke about drawing on a sense of awareness as part of their self-care. They highlighted having an awareness of themselves and their own capacity, needs, and wellbeing, as well as an awareness of the demands being

placed on them at any particular time. This is illustrated by Eva, discussing the key components of self-care:

Eva: I think the key is what you said, being aware of the situation, the system around you, yourself, your own strengths and weaknesses, other people's strengths and weaknesses, being like a little buddha outside of the system ... Kind of always taking a step back, always reminding myself: *take a step back, look at the situation*. And then I can care for myself and be healthy mentally and physically.

A number of participants highlighted the mindful quality of this awareness, noting that this facilitates them in "opening out a bit and having a bit more perspective" (Sam). Emma expanded on how being more mindful helps her to manage work stressors:

Emma: I've become more mindful, better at tolerating that internal sense of, sometimes you get when you get those emails about targets, or something that you've accidentally messed up, or you know, whatever it is, somebody you're worrying about.

Participants also explored the need to be aware of their own wellbeing; a number of participants indicated that they understood their own self-care to include mindfully 'checking in' with themselves, often noting that this was not a conscious activity:

Emma: I think different kinds of self-care are more conscious and unconscious to me. There are some things I do less consciously, like the mindfully-ness, sort of checking in.

Catherine: I don't stop and think *right time to check in, how am I feeling?* You just do it.

Participants also underlined how maintaining an awareness of the origin of their feelings formed part of their self-care. They considered the need to acknowledge this to themselves or to others:

Emma: I guess sometimes the thing that I find helpful particularly with colleagues, or a lot in supervision, is just talking about the impact that these things that are around have.

Yasmin: And there's almost like, having that awareness, but noticing that might be a bit of an accumulation of your own trauma, from having the impact of everything that we hear all the time as well. It's just bearing that in mind and knowing that it might influence the way. Cus I know, suddenly, a few times when I haven't been so aware of that, and, I've not quite forgotten, but put to the back of my mind, like, *oh, just been and you know, saw five people today, and there's a lot going on for each of them*, and then I go home and then been making my daughter's dinner or whatever, just getting back in to family life straight away, and without actually stopping to reflect for a moment, where it's suddenly caught up with me and I feel a ratty mood or something, like the next morning, I've had to think *why am I feeling so rubbish?* And then, it clicks *actually there's loads of stuff I haven't really processed*.

Across the groups, participants emphasised how having an awareness of one's own needs is also an integral part of self-care. Emma wondered whether the structure of supervision within therapeutic professions allows therapists to acknowledge their own needs more easily:

Emma: It's embedded within our whole structure and our whole hierarchy, in a way ... we don't see it as some kind of admission of incompetency to be supervised, whereas I think that's quite different in other professions. And I think that must affect how we self-care: that it's ok to be needy in some way, or to have needs. And they need to be met by somebody. That's sort of entrenched in our system, in our profession in a way.

As well as acknowledging one's needs, participants also raised the necessity of being aware of one's own capacity and limitations, as well as others' expectations:

April: I try and think about, you know, what's possible, what can I do in this place at this time, that's realistic.

Yasmin: Yeah, just being realistic about it. Knowing what your own capacities are, and what the interface between expectation and capacity isn't it, actually kind of just being honest about where you're at with it.

Being able to I say *I can't quite meet what the expectations are*, as well sometimes.

Zoe: There is something about being more authentically oneself at work, as well, with regard to, you know, we have got limitations, and there are only so many things we can do in a day.

As illustrated by these extracts, participants indicated that they understood self-care to include an awareness. As well as being aware of their own wellbeing, needs, and capacity, participants spoke about how this awareness extends to others and their expectations. Some participants spoke about this awareness having a mindful quality to it. The way participants spoke about awareness is qualitatively different to how they spoke about particular restorative activities; this awareness appears to be ongoing, and is sometimes unconscious.

3.2.2 Being Boundaried

Participants also explored how being boundaried is part of their self-care, giving illustrations of physical, temporal, and relational boundaries in and outside of work. In discussing what self-care means to her, April spoke of her use of boundaries in her relationships with others:

April: It [self-care] is about how you manage that kind of boundary between what you want and need, and what others want and need from you.

Eva also spoke about boundaries with others, considering how the capacity to be boundaried is linked to the awareness discussed in the previous subtheme:

Eva: Now I'm much more true to myself. I have an awareness of what I can actually do and not do, and that it's ok. In the past it wasn't that much ok, I had more guilt about not doing things for other people or in the work place, but now I'm trying to be more protective of myself. So boundaries could be part of self-care.

Participants also discussed being boundaried in their personal relationships, particularly in terms of "avoiding psychology talk outside of work and in the family" (Alice):

Sue: I call it bus stop psychology, where if you let your defences down and you're friendly and kind, you can get sucked into many other things. So my [self-care] toolkit has now got something in that is about *it's alright to be polite and nice and lovely and friendly, but say no*.

Alice: You just think *I don't want to have those types of conversations outside of work!* Because I just haven't, I just don't want to. I want it to be light and not thinking about stuff in depth all the time, and thinking about all the different ripples of interpretation and peoples' points of view.

Mia: I go to toddler groups and things, and it's kind of being mindful about how many conversations I actually engage in about their child's problems! You know, not wanting to hear information about their work, hoping people don't start asking me questions about different things.

In discussing the different ways that they are boundaried, many participants underlined the need for a boundary between "work and not work" (Zoe). A number of participants spoke about the necessity of a "physical separation" (Louise) from work, in terms of location or activity:

Emma: To me, being completely away physically, mentally, and doing very different things with my life is part of that [self-care]. ... Because I find the two do blur. That things pop into my mind a lot, and I sometimes think that physical distinction can sometimes be the thing that helps me to think *I don't need to think about that work right now, I'm doing something else*.

Louise: I find when I'm going home and it [work] is going round and round in my mind, then going out and doing something very different becomes more important.

A number of participants gave examples of engaging in exercise as an activity that provides a psychological boundary with work, due to it being "completely different" (Catherine):

April: I like to get completely away from psychotherapy when I'm not working. I do lots of exercise. Tennis and yoga, just completely get away from psychotherapy.

Yasmin: It is such a heady job, isn't it as well. There is something about, and you talked about exercise as well, there's something about just physically getting back into your body somehow.

A number of participants also raised their use of boundaries regarding the time they spent at work. April spoke of the importance of this for her:

April: It [self-care] means, for me, taking myself away from the work enough to ensure that I'm not overtaken by it.

Expanding on the use of time as a boundary, some participants spoke of being boundaried in ensuring they leave work on time, whilst others spoke about choosing to work part time as a way to be boundaried:

Sue: I've done the boundarying it by going: *I'll do two days; have those two days with pleasure, but in return for that, I'm gonna look after myself in a very different way.*

Emma; I think one of the things that I have managed to stick to so far is leaving [work] pretty much on time and trying not to work on laptop at home.

Discussing the ways that being boundaried forms part of their self-care, participants are once again illustrating how they understand that self-care can be an ongoing way of being.

3.2.3 Being Aligned with Values

Participants also spoke about self-care as living a "values based life" (Sue), with a number of participants speaking at length about how their values influence their approach to themselves and others. Values were particularly discussed with regard to "getting the work-life balance right" (Sue), "retaining that connection to the work" (Sam), making careful career decisions, and maintaining a "life outside of psychology" (Sam), which were all emphasised as important aspects of self-care.

A number of participants explored self-care in terms of ensuring that the way they work is in line with their values:

Sam: I suppose for me, because the idea of the work really being very personally meaningful and connecting with my values is really important, and I think if the work ceases to become like that ... then it's not good from a self-care point of view.

Harry: Being in an environment where you can get on with the bit of the job that you value the most ... is highly attractive to my value system. ... That might connect very centrally for me in terms of self-care: that if it doesn't feel meaningful and rewarding, why am I doing it?

Other participants also spoke about how self-care and their values are linked to their work; a number of participants spoke about sacrificing career progression as an outworking of self-care, which enabled them to live and work in a way that was more in line with their values. Sue spoke of her decision to reduce the hours she worked in terms of self-care; for her, this meant "letting go of the career ... [and acknowledging] *I'm not going to be a consultant*". Ed spoke about how he had seen the impact of this on Sue, how she had made "a real shift ... to take some of that career and exchange it for some of this life thing". Alice also made explicit links between self-care and her decision to sacrifice career progression:

Alice: I will sacrifice any kind of career progression just to be in between two times, and then go home and spend time with my family and that feels like a massive self-care. ... I've done the more management stuff before ... but I would rather stay like this and look after myself than be doing that. Like the stuff that isn't valued so much isn't it, I'd rather be doing that with people and feeling like I've done a good job.

Although she does not label them explicitly as values, in this extract Alice emphasises how important it is to her to have time to spend with her family and to feel like she had done a good job at work, commenting how for her, that is self-care.

In discussing how their values linked to their self-care, a number of participants spoke about their priorities, noting how these had "changed with time" (Sam). Some of the participants who were parents explored how having children changed their own relationship with self-care. Many spoke about how it became

more difficult to have time to oneself, but that having children was a “big perspective changer [which] made it much easier to leave work at work” (Sam). Similarly, Zoe commented that “it’s become easier for me to have a sense of perspective since having children. Cus otherwise it’s easy to be completely consumed by work”. Zoe went on to emphasise that, for her, self-care and a sense of perspective went “hand-in-hand”.

Sue also noted how the expression of her values-based living had changed over time. She linked self-care with considering her legacy as she got older, exploring how for her, this meant that self-care related to more than just how she treats herself:

Sue: It’s that none of it goes with you. And self-care about journeying towards a life where you look back ... What kind of legacy ... or memory or thing are you going to leave behind? And actually I want to tread gently on the world. And so the self-care in that is to not care just for me, but to think about the planet, and everything in between individuals and the planet.

Similarly, Mia linked living according to her values with her understanding of self-care, and spoke about how together, these influence her approach to others:

Mia: The meaning in life is a really big thing for me. And part of that, I want my family and my friends to be well, and sometimes about facilitating that.

Facilitator: So how does that relate to your self-care?

Mia: I guess, you know, when you feel that you’ve contributed to wellbeing, like my sister’s been having a bit of a health problem. ... It’s important for me that she’s well, so that meant I’m spending extra time talking to her, and supporting her through the journey that she’s going on, and it makes me feel like a better human being. It’s not necessarily selfish, cus I actually care about her, I want her to be well. But I think it goes to my value system, family and those that are important, and their wellbeing is important.

As demonstrated by these extracts, participants spoke about how they considered being aligned with their values as part of their expression of self-care. Once again, this indicates that participants had a complex understanding of self-care, in which self-care is a way of being that relates to both themselves and to others.

3.2.4 Self-Compassion

Participants noted the importance of one's attitude towards oneself in relation to self-care. Yasmin emphasised the importance of "noticing that you are there, you are important and that you have a right to take care of yourself, fundamentally". A number of participants drew on the concept of self-compassion as part of the discussion, highlighting how they "try to be a bit compassionate" (Tanja) towards themselves.

However, in discussing self-compassion and self-care, participants spoke about the complex relationship between the two concepts. A distinction was drawn between self-care and self-compassion: Catherine commented that "they're not unrelated. But I don't think they're quite the same". The first focus group discussed this at length, concluding that self-care is "a component of [self-]compassion (Louise), but that self-care "is not enough by itself to be compassion" (Catherine). The group felt that self-compassion included a component of "facing difficult things and taking responsibility for things that you might actually want to avoid" (Catherine), which they did not consider self-care to include; they felt that self-care was about "less of the more difficult stuff" (Harry). As well as considering self-care to be a component of self-compassion, however, it was also expressed that without self-compassion, self-care could be more difficult, potentially being viewed as self-indulgent:

Louise: I think you probably have to have compassion before you can engage in self-care. I'm thinking with people who don't have a very compassionate stance towards themselves, it's then very difficult for them to self-care, because it gets viewed in a more self-critical way, as self-indulgent.

3.3 The Challenge of Self-care in the NHS

This theme explores the way participants spoke about self-care in the context of working in the NHS. In discussing engagement in self-care at work, participants emphasised how the culture of the team they are (or have been) in has affected their own engagement in self-care. Participants also highlighted more distal NHS systems which made engaging in self-care difficult; most notably, participants spoke about the effects of feeling under constant pressure to meet targets. This led participants to feel that the NHS systems function in a way in which outcomes are valued more than both staff and service users. Finally, a number of participants referenced an 'agenda' around self-care in the NHS, noting how this is not aligned with the self-care that employees would like to be supported with. Participants indicated feeling that that self-care is sometimes proposed as a means to manage the stress of working in the NHS, when in fact more systemic issues may need to be addressed.

3.3.1 Influence of Team Culture

Participants spoke about how the culture of their team makes a difference to their own psychological wellbeing and ability to self-care. Sam noted how a team can facilitate self-care:

Sam: Some aspects of the system we create as well, and so how we work with each other, how we relate with each other, how we behave in our teams for example, those sort of things are really important as well, and that, I suppose, help create an atmosphere that is conducive to self-care.

Participants spoke about the importance of feeling supported professionally and personally, and how this relates to their own self-care. Alice reflected on the caring nature of her team and how this fosters her own self-care:

Alice: It's nice to be able to be in a job where I can say to my supervisor *I'm really struggling right now* and then our little therapist team takes care of each other, so it does feel very like, caring, self-caring.

A number of participants spoke about the importance of “connecting with the people you work with” (Sam). Louise noted how connecting with her team was important in terms of self-care:

Louise: I think having that sense of connection, when services are becoming so fragmented, is important for professional self-care, if you like, to gain support and that sense of comradeship with fellow psychologists, therapists. I feel that’s important. ... We often try to eat our lunch together, so that we can debrief about clients, or share chocolates that patients have given us or something, you know, those kind of things feel quite self-carey.

Participants discussed how team attitudes towards self-care can also make their own engagement in self-care more difficult; how when others have “a certain type of work ethic, that doesn’t fit with [one’s] kind of idea of self-care, that that’s quite hard.” (Alice). Emma contrasted her experience of working across two different teams, expanding on how the differing attitudes the teams influenced her self-care and her psychological wellbeing:

Emma: I work in two different teams, one is entirely psychology, and one is MDT. And the difference in my stress levels is massive, in comparison that it is much easier to self-care, to feel cared for, in the psychology team than it is in the MDT. And the effect of my colleagues has a drip-drip effect on me as well. There are many more of those kind of *must work harder* dynamics, and *don’t complain* and *you’re not here to have fun*. There are many, many narratives that I hear a lot, that I think are the team’s way of dealing with it, but I don’t think it’s a very self-caring way of dealing with it. And it’s interesting that that affects me emotionally.

Some participants noted how the expectations of working so hard had an effect on them. Sue recounted how she had managed that pressure:

Sue: I had a turning point ... where it was piling on, I was on a conveyer belt of non-stop working, many, many hours, and I scored myself on the Hospital Anxiety and Depression Scale ... and I scored quite highly for anxiety, which wasn’t surprising, and just tipping into mild clinical for

depression, and ... then I went into proactive [self-care] mode at that point ... and had to put a package of care in for myself.

3.3.2 Influence of Organisational Culture

Participants also spoke about how the wider systems within the NHS influence their own self-care. A number of participants referenced the organisational culture of the NHS, as well as the wider political system in which the NHS functions.

Ed highlighted how therapeutic work is a “thoughtful ... and demanding task”, which is not acknowledged by the wider system: “the Trust is very, umm, don’t account for the emotional labour almost, it’s task oriented, isn’t it”. In considering the task-oriented nature of the wider system, it was noted that this made self-care more difficult; participants frequently mentioned the effects of increasing pressure and “blimmin’ targets” (Yasmin):

April: I think one of the things that gets in the way of self-care for me is this idea of targets. ... You know, kind of getting emails saying like targets are, I don’t know, three percent down (laughter) ... it’s like, *you must work harder!* (laughter). Just kind of balancing that kind of political pressure that everyone’s under, the organisation, isn’t it. So there is a place for self-care, and a place for reflection, and not just a case management approach.

Zoe noted how the organisational culture has an effect on self-care, emphasising how this is counterproductive in the long run:

Zoe: So efficiency is good, but an ultimate loss of flexibility is bad, and does take away from the ability to kind of have the kind of working environment which does promote kind of self-care, on the job as it were. Which I think leads to more efficiency, ironically, and that’s been kind of stripped out of the system. The danger is that it can be stripped out of the system if it becomes just ever more regimented, rigid.

Expanding on the difficulty of self-care in the NHS, a number of participants spoke about feeling that “further up [in NHS management] they don’t get what

self-care is. They block it.” (Alice). Mia noted how ultimately, the NHS does not function in a way that promotes psychological wellbeing or proactive self-care:

Mia: If you think about it, the whole NHS is structured around a crisis model. Managing crises, meeting demands of the crisis, rather than staying well. And I think as human beings that work for the NHS especially, we tend to follow the line of that model quite nicely a lot of the time.

The way participants spoke about the pressure of targets and task-oriented nature of the NHS indicates an underlying feeling that participants felt that in the NHS, outcomes are valued over staff and service users. As well as feeling devalued themselves, participants gave examples of when they did not feel their work was understood or valued:

Emma: All the changes and the cuts and all the political climate and everything could make you feel so incredibly helpless and devalued.

Mia: I end up avoiding taking about certain things [with managers] I know just they’re not going to be able to understand. Like a long time ago I was asked by a manager if the systemic work that I do that takes about a couple of years, could be done by email by an Assistant [Psychologist]. And I didn’t know what to say!

Ed: No! It’s mind-boggling isn’t it. It almost doesn’t warrant a response, does it.

This is significant in terms of self-care, as participants noted that feeling valued directly links to self-care: Louise stated that “when people feel valued, maybe they’re a bit more able to self-care”.

As illustrated, participants emphasised how the organisational culture of the NHS makes engagement in self-care more difficult. Interestingly, participants also spoke about using self-care to manage the pressure they experienced. Using emotive language, Ed expressed how the NHS context of his work is particularly challenging, and how self-care is necessary to manage that:

Ed: I think the psychology bit is really fulfilling and I really enjoy that. I just think doing that in the NHS is just dreadful. And I think it’s an

absolute negative, if that makes sense. So I think actually, something that should add to this sense of wellbeing I think actually needs to be really, kind of, managed and sort of detoxed in other bits of my life.

Participants spoke about how making careful, values-based decisions about their work facilitated their self-care in challenging circumstances:

Zoe: And also just give, umm, apportioning the responsibility to the correct place, so if the system is like that, and this is how I have to work then, so where can I make the changes to how I practise whilst trying to maintain the values that I've got that make the job meaningful?

Rob: I think that's a really important point about picking your fights, knowing when you can, because otherwise if you try to change something and you can't, then bashing your head against a brick wall all the time is just going to stress you out and you're not going to be self-caring.

Others spoke about managing NHS working by reducing their days and supplementing this with private work, or wondering whether this is "even a job that I should or can be doing full time" (Emma). Yasmin spoke explicitly about how she considered having time working outside of the NHS as self-care:

Yasmin: I took, sort of reduced my hours once I came back from maternity leave and kept it that way. Partly I think because there's a bit of an ambivalence there about working, and just to have time outside of working in the NHS felt like self-care as well.

3.3.3 Self-Care Agenda in the NHS

Some of the participants mentioned that self-care seems to be a current agenda in the NHS. Ed drew a distinction between the self-care that is offered by the Trust, and the self-care that employees would find helpful:

Ed: I think the Trust have got some ... sort of agenda around self-care, but I'm not sure it really fits with what people really think is important, if that makes sense.

Participants spoke about how their Trust offers activities and courses which seek to improve staff wellbeing:

Ed: I've just seen invitation to CBT in the workplace, and conflict resolution and getting along nicely with each other. So the Trust have got the kind of push on wellbeing haven't they for staff.

Sue: They have, but missing the point a bit.

Ed: But actually, it's not what we choose.

Sue: No, it's not.

Clearly, these participants feel that the Trust may be able to improve its efforts to support staff with self-care. Although this was not explicitly discussed, in the way participants spoke there appears to be an underlying criticism of how the NHS uses narratives around self-care. Sue noted the differing approaches of the Trust and individuals:

Sue: The Trust is looking at it strategically, and we're living the value-based life of *how do we self-care*, which is a very different thing.

As discussed in the previous subtheme, participants were clear about how increasing pressure and workloads leave them feeling overwhelmed. A response of the Trust appears to be the suggestion that staff improve their own psychological wellbeing via self-care, rather than addressing the pressure of increasing workloads. Participants considered how, at times, self-care simply is not sufficient. Sue illustrated this, recounting a time when practical support was needed to improve staff wellbeing, rather than self-care:

Sue: We had a moment where our manager ... was saying *what can we do to make you all feel better?*, and we're saying *we need that other member of staff that you've cut, because actually, if we'd got enough staffing, like that staff that you promised us, then we'd all function much more better and feel better because that theme of we get all our work done and be able to go home at five o'clock, and go 'lids on it tonight' because everybody and everything is lined up as it should be, so we can then go and be free to do what we need to do*. So we argued vociferously that our wellbeing would be improved by another member of staff, and no amount of mindfulness or CBT would fix that for us.

Mia: It's about practical things.

Sue: It was. It was that actually we need money to make that difference.

4. DISCUSSION

The aims of this study were to explore what self-care means to NHS therapists in both principle and practice. As well as gaining and understanding of how therapists understand and engage in self-care, the study also aimed to explore the individual and systemic factors which facilitate and hinder self-care.

Following the analysis of four focus groups with therapists working in the NHS, three main themes were identified in the analysis. The themes were: 'Self-care as restorative activities', 'Self-care as a way of being', and 'The challenge of self-care in the NHS'. This chapter discusses the study's findings in relation to the research questions and the literature. Potential implications for policy, practice and research are then explored, before presenting critical reflections on the study. Finally, a conclusion is provided.

4.1 Present Findings in Relation to the Literature and the Research Questions

In this section, the research questions will be taken in turn, discussing how the findings of the study speak to these questions and to the literature base.

4.1.1 How do NHS Psychologists and High Intensity Therapists Describe Their Understanding of Self-Care?

The participants' understanding of self-care is reflected throughout the first and second main themes: 'Self-care as restorative activities', and 'Self-care as a way of being'. As the titles of these themes might suggest, participants indicated that they understood self-care in multiple, and potentially conflicting ways.

4.1.1.1 Self-care can be understood as discrete activities

Forming the content of the first theme, participants spoke about intentionally engaging in activities that they considered to be self-care, due to the perceived restorative effects of such activities. The activities highlighted in this theme were denoted as self-care due to their restorative effects. Participants gave a wide range of examples of activities, all of which have been proposed in the literature as methods of self-care. Examples of such activities mentioned by participants

included exercise (also suggested by Shanafelt et al., 2003), personal therapy (also suggested by Baker, 2003), reading (Carroll et al., 1999), being in nature (Walsh, 2011), spending time with friends and family (Eckstein, 2001), taking annual leave (Lawson, 2007), and sleeping (Baker, 2003).

Such activities appear to fit into the areas of self-care commonly proposed in the literature, of physical, psychological or emotional, relational, and spiritual wellbeing (e.g. Richards et al., 2010; Wise & Barnett, 2016). Indeed, one of the participants mentioned the importance of “keeping ourselves well, ... mentally, physically, emotionally, socially”. At face value, participants did not appear to discuss a spiritual aspect to self-care; this is discussed further in section 4.1.1.3.

Participants were not explicitly asked why they might engage in self-care. However, they spoke about using the restorative effects of such activities to offset the effects of therapeutic work, and related this to having a professional responsibility to keep themselves well. This understanding of self-care as a professional or ethical responsibility mirrors the reference to self-care in professional guidelines (e.g. BPS, 2018), and recommendations to engage in self-care through the literature (e.g. Barnett & Cooper, 2009).

4.1.1.2 Self-care can be understood as a way of being

The second theme relates to participants’ discussion of how they could be self-caring in the way they are oriented to themselves or others. Self-care has not previously been framed in the literature as a way of being, however, each of the examples given by participants do appear in the self-care literature. These are explored below by looking at each of the subthemes of the second theme ‘Self-care as a way of being’.

The first subtheme, ‘Being aware’ considers how participants understood awareness as part of self-care. As well as being mentioned in qualitative studies on self-care (e.g. Coster & Schwebel, 1997, Harrison & Westwood, 2009), self-awareness was consistently endorsed as ‘highly important’ by participants in a number of studies using the CSBQ to ascertain which behaviours are considered important in maintaining professional functioning (Lawson, 2007; Lawson & Myers, 2011; Rupert & Kent, 2007). Participants in this study similarly

spoke about an awareness of their own wellbeing, needs, and capacity, and extended this to having an awareness of others and their expectations. In discussion of awareness, participants' drew on the concept of mindfulness. As discussed in section 1.5.1.1, Mindfulness is also discussed at length in the self-care literature, and it has been proposed that the mindful nature of self-care may explain the positive effects of caring for the self (Richards et al., 2010).

The second subtheme, 'Being boundaried' draws on participants' discussion of how using boundaries to maintain their psychological wellbeing. Much of the discussion of boundaries in the literature relates to boundaries between the personal and professional realm (e.g. Harrison & Westwood, 2009), and maintaining boundaries in professional and therapeutic relationships (e.g. Baker, 2003). In this study however, participants spoke about the importance of boundaries across their lives, giving examples of being boundaried in their personal and professional relationships, in their use of time, and in their activities.

The third subtheme, 'Being aligned with values' relates to the way participants spoke about living in line with their values. Values are discussed in the self-care literature, particularly by those that draw on ACT as an approach to self-care (e.g. Pakenham, 2015). Participants often spoke about self-care and their values in terms of choosing to work in an environment which allows them to work in a way that is in line with their values or in terms of sacrificing career progression, again reflecting the self-care literature (e.g. Coster & Schwebel, 1997). Participants also considered self-care to extend further than themselves, speaking about values related to looking after the environment, for example. Although discussed less in the self-care literature, this may relate to Alani and Stroik's (2015) discussion of selfless self-care, which related to activities that contributed to the community.

The fourth subtheme, 'Self-care and being self-compassionate' denotes participants' discussion of the relationship between self-care and self-compassion. Echoing the literature (e.g. Sinclair et al., 2017), a number of participants mentioned self-compassion as important to self-care. Some discussed self-compassion and self-care at length, wondering whether self-care could be considered as a part of self-compassion; this reflects the

conceptualisations of self-compassion suggested by both Neff (2003) and Sinclair et al. (2017).

4.1.1.3 Do participants understand self-care to include a spiritual aspect?

As previously mentioned, the participants in this study explicitly spoke about physical, emotional, relational, and cognitive self-care. On the surface, they did not appear to discuss spirituality, a topic commonly discussed in the self-care literature (e.g. Norcross & Barnett, 2008; Santana & Fouad, 2017; Wise et al., 2012). However, it should not be automatically assumed that the participants do not understand self-care to include a spiritual aspect.

Brown (2010) proposed a definition of spirituality: “recognizing and celebrating that we are all inextricably connected to each other by a power greater than all of us, and that our connection to that power and to one another is grounded in love and compassion.” (p. 64). Brown went on to suggest that “practicing spirituality brings a sense of perspective, meaning and purpose” (p. 64). In this sense, participants’ discussion of self-compassion and self-care as being aligned to their values may relate to a spiritual aspect of self-care. Indeed, although much of the self-care literature speaks about self-care at an individual level, participants in this study spoke about how they understood self-care to be about more than the individual, drawing on examples of understanding their self-care to involve contribution to the wellbeing of others and of the environment. This also seems to be reflective of Santana and Fouad’s (2017) understanding of spirituality as self-care: they reference ‘activities for the greater good’ as a way to understand some items which load onto their ‘spiritual’ factor.

Santana and Fouad (2017) referenced mindfulness as a way to understand the remaining items loading onto the factor of spiritual self-care. Mindfulness was also discussed by the participants in this study, particularly in relation to ‘checking in’ with themselves, and having a ‘mindful awareness’. This reflects how mindfulness is commonly spoken about in therapeutic contexts, for example in Mindfulness Based Cognitive Therapy (Segal, Williams, & Teasdale, 2013). However, Western psychology has been criticised for coopting a simplified version of mindfulness from Eastern philosophy and Buddhism, where

mindfulness and related concepts have been reified, diluted, distorted, and denatured (Grossman & Van Dam, 2011; Kang & Whittingham, 2010). Thus, care needs to be taken in the designation of participants' references to mindfulness as spiritual, particularly as they did not describe their practice of mindfulness in these terms.

It may also be that the context of this research made it less likely for participants to explicitly discuss spirituality. The vast majority of studies about self-care have been conducted in North America, where belief in a deity and/or religious affiliation are more common both in the general population (Department of Health, 2009; Putnam & Campbell, 2010) and in therapists (Bilgrave & Deluty, 1998; Smiley, 2001) than in the UK. Therefore, it may be more common for therapists in North America to speak about spirituality, leading to the inclusion of spirituality in much of the self-care literature. Research conducted in the UK with Clinical Psychology Trainees found that participants find it difficult to talk about personal and professional issues related to religion, and even more so to spirituality (Begum, 2012). Thus, participants in this study may have been unlikely to explicitly relate their understanding of self-care to spirituality, particularly in a group context. However, it may be that participants' discussion of values-based living and mindfulness supports the literature in framing spirituality as an important aspect of self-care.

4.1.1.4 Summary

Participants demonstrated an understanding of self-care both as activities to do, and as a way to be. This distinction, and the concept of self-care as a way of being, have not previously been proposed in the literature, however, the examples given by participants have each been documented in previous publications. The same participants spoke about self-care as both activities and a way to be, and did not appear to perceive any conflict in holding both understandings. This is in line with the recent suggestion by Dorociak et al. (2017), that self-care can be understood as multifaceted.

These understandings, as well as the specific examples of self-care that participants gave, appear to fit into the areas of self-care proposed in the literature: physical, psychological or emotional, relational, and spiritual wellbeing

(e.g. Richards et al., 2010; Wise & Barnett, 2016). Participants did not explicitly discuss a spiritual aspect to self-care, however it may be that their discussion of mindfulness and values relates to spirituality.

Participants spoke of needing to self-care in order to sustain their wellbeing, drawing on the concept of a professional responsibility to be well. This understanding of self-care as an ethical or professional responsibility echoes the inclusion of self-care in ethics codes (e.g. BPS 2018).

4.1.2 How do NHS Psychologists and High Intensity Therapists Describe Their Engagement in Self-Care?

The way self-care is understood naturally relates to the practice of self-care. The distinctions in understandings of self-care drawn above are therefore similarly reflected in engagement of self-care: participants spoke about specific activities that they might do, and ways of being that they might adopt. As the previous section discussed these at length, this section will instead focus on a more nuanced distinction in the way participants spoke about their approach to self-care, that of proaction and reaction. This distinction forms the basis of the subtheme 'Proactive and reactive self-care', which comes under the theme 'Self-care as restorative activities'.

As discussed in section 1.6, a number of authors in the self-care literature present an argument for a proactive approach to self-care. Norcross and Barnett (2008) suggested that this is necessary to maintain professional competence. Indeed, a number of publications about self-care propose that only taking a reactive approach to self-care is insufficient (e.g. Barnett & Cooper, 2009; Norcross & Barnett, 2008). It is argued that without proactive self-care, there is potential for psychological distress to impact on professional functioning (Wise et al., 2012), particularly as the experience of psychological distress may be associated with reduced self-monitoring and awareness (Skovholt et al., 2001). Of note, this study's findings also suggested that a sense of awareness may itself form a significant aspect of self-care.

Many participants spoke about noticing the impact of their job on their psychological wellbeing, and indicated that they use self-care to offset those

effects. Some participants spoke of making plans for activities ahead of time, or having a routine of self-care. In contrast, other participants commented that their self-care was not something that they consciously considered; they noted that they appear to have a 'boom and bust' cycle which resulted in them only turning to self-care when they were stressed. When a plan or routine of self-care behaviours was discussed, participants seemed to emphasise taking a more protective approach towards themselves, using self-care proactively as a means to maintain their psychological wellbeing. Alternatively, when self-care was spoken about in terms of a 'boom and bust' cycle, this emphasised a more reactive approach to self-care, as a means to restore wellbeing when feeling depleted.

It was beyond the scope of this study to evaluate whether certain approaches to self-care are more effective than others. However, the participants who spoke of taking a reactive approach to self-care appeared to indicate that they would like to be more proactive. Indeed, when reflecting on the discussion towards the end of the focus groups, a number of participants indicated that they planned to give their self-care more thought going forward.

4.1.3 How do NHS Psychologists and High Intensity Therapists Describe Their Views on What Facilitates Self-Care?

The participants' discussion of the facilitators of self-care is particularly reflected in the second and third themes: 'Self-care as a way of being' and 'The challenge of self-care in the NHS'.

Discussed as part of the second theme, participants spoke about a number of their own stances which they linked to self-care, including having a mindful awareness of themselves and others, self-compassion, being aligned with their values, and being boundaried. With the exception of self-compassion, participants labelled each of these as self-care; as discussed in section 4.1.1.2. However the way participants spoke about the attitudes or stances also implied that these could also facilitate self-care, indicating that they may understand there to be a complex relationship between the facets. For example, participants explicitly named having a mindful awareness as self-care, but also about how they might 'take a step back' to gain awareness, and then they can

self-care. Similarly participants indicated that they understood values-based living to be a form of self-care, but also spoke about how intentionally living in accordance with their values facilitated their engagement in self-care; an example of this would be their values prompting them to be boundaried with the time they spent at work. As illustrated, participants were often unclear about which aspect they considered to be the self-care: the stance, the behaviour that the stance prompted, or both. As discussed further in section 4.3, it would be useful for future research to elucidate the relationship between these different factors.

In terms of self-compassion, participants proposed that self-compassion may facilitate self-care; it was proposed that without a self-compassionate stance towards oneself, self-care might be considered self-indulgent, and as such, more difficult to engage in. This is in line with the literature around self-care and self-compassion: Coleman et al. (2016) suggested that a self-compassionate stance may influence beliefs about being deserving of self-care, and Brownlee's (2016) participants reported finding self-care difficult to prioritise due to feelings of guilt and self-indulgence. Interestingly, participants also felt that self-care may form an aspect of self-compassion, as recently suggested by Sinclair et al. (2017). Participants thus indicated that they understood there to be a complex relationship between the concepts of self-care and self-compassion, which reflects the current literature (Sinclair et al., 2017; Yip et al., 2016).

Discussed primarily in the subtheme of 'Influence of team culture' within the third theme, participants spoke at length about relational factors: the influence of others on their own engagement in self-care. Participants emphasised how feeling cared for and valued by others facilitates their self-care; they used examples of how, by caring for one another, teams can create atmospheres conducive to self-care. Discussed further below, this was contrasted with examples of how others can make self-care more difficult, such as in teams where there is pressure to continually work harder.

4.1.4 How do NHS Psychologists and High Intensity Therapists Describe Their Views on What Hinders Self-Care?

The factors which hinder self-care are predominately reflected in the third theme, 'The challenge of self-care in the NHS'. Participants noted that the opposites of the previously discussed factors that facilitate self-care are likely to hinder self-care, but placed a particular emphasis on pressure and others' expectations as hindering self-care.

Participants emphasised how the expectations, attitudes, and narratives of those around them could hinder their own self-care, written about as part of the subtheme 'Influence of team culture'. Speaking about the teams they worked in, participants discussed how others sometimes had attitudes towards self-care which seemed different to their own, and they noted the effect this had. For example, participants commented that others' narratives and attitudes about working overtime or not having fun at work affected their own ability to engage in self-care. The influence of others is not included in Bettney's (2017) categorisation of barriers to self-care into personal, professional, and systemic factors. Indeed, the topics of barriers to self-care and the influence of others on self-care care do not appear to have received significant attention in the literature, and therefore may benefit from further research.

Forming the subtheme 'Influence of organisational culture', participants also spoke of the effects of wider NHS systems on their self-care. Numerous participants highlighted the impact of targets, indicating that consistently feeling under pressure does not facilitate taking a self-caring stance towards oneself or engaging in self-caring activities. This discussion of pressures on NHS staff is reflected in the literature (e.g. Felstead et al., 2013; Wilkinson, 2015), discussed in section 1.4.2. Participants particularly noted how the increasing emphasis on efficiency within the NHS reduces flexibility and ultimately forms a barrier to staff self-care. They commented that this is ultimately counterproductive, as they felt that self-care can itself lead to better efficiency. These conclusions are similar to Bettney's (2017) reflections about how the increasing pressures placed on NHS clinicians inhibits self-care.

4.1.4.1 The role of the NHS in staff psychological wellbeing

Participants' discussion about the factors which facilitate and hinder engagement in self-care indicate that self-care may not be only down to the individual. Indeed, such an understanding has been suggested as having the potential to justify blaming of the individual for not coping with unmanageable pressures (Norcross & Barnett, 2008). It is perhaps therefore important not to take an individualised view of self-care, as this could allow for decreased psychological wellbeing to be attributed to not being 'good enough' at self-care when this may not be the case (Pakenham, 2015). Discussed in section 1.9.1, Barnett and Cooper (2009) suggest that creating a culture of self-care should be considered the responsibility of the individual, the profession, and the employer.

As mentioned, participants spoke about self-care in the context of the NHS, which formed the basis of the third theme. Included in the subtheme 'Self-care agenda in the NHS', participants wondered about the approach to self-care taken by the NHS, noting that many Trusts offering provisions to support staff wellbeing, such as mindfulness or CBT courses. However, the participants also spoke about how these provisions are not in line with the support with self-care that they would want, and suggested that that supporting self-care is not sufficient when other interventions may be necessary, such as more financial resources. This is in line with the writing of Grawitch et al. (2015), who highlighted how stress management efforts in the workplace often focus on the individual level, without making changes to the organisational practices which led to the stress.

Participants did not explicitly discuss how the concept of self-care has the potential to be used to place blame on an individual for not coping in the context of increasing pressure and workloads (Pakenham, 2015). Due to the focus of the research questions on participants' understanding of and engagement in self-care, the interview questions may not have encouraged participants to be critical of the concept of self-care, or how it is used within the NHS or in wider society.

4.2 Implications for Practice

Summarised in section 1.7, much of the self-care literature makes very specific recommendations about what therapists should do as part of their self-care. However this study demonstrates that it is possible to engage in self-care in substantively different ways. This supports Norcross and Barnett's (2008) criticisms of the literature's focus on specific self-care activities and behaviours. Creating prescriptive recommendations has the potential to give the impression of a few 'correct' ways in which to engage in self-care, alternatively, attempting to provide an all-encompassing list of self-care could be overwhelming as it would be so broad and long. Instead, this study's findings would suggest that self-care principles, such as those proposed by Norcross and Guy (2007) are more likely to be of use than the recommendations of particular activities and behaviours found throughout the self-care literature. In line with this, no specific recommendations about particular methods of self-care shall be made, as this study did not seek to evaluate the efficacy of particular forms of self-care. However, this study has potentially significant implications which should be explored on individual, team, and wider systems levels.

4.2.1 Individual Level

Considering implications for individuals, the results of this study that self-care can be understood in different ways implies that individuals may benefit from working out their own engagement in self-care. Individuals may find it helpful to reflect on which self-care activities they have found to be more effective, and to consider how and when they incorporate these activities into their life. It may be useful for individuals to consider whether they would like to take a more proactive or reactive approach to such activities. Furthermore, Individuals could consider whether they want to engage more intentionally with some of the self-caring ways of being identified in this study: that of being aware, being in line with values, being boundaried, and being self-compassionate.

4.2.2 Team Level

As well as encouraging individuals to engage in self-care in a way that they find to be effective, this study draws attention to the importance of the role of others

in self-care. The results of this study emphasised the role of the wider team in self-care at work, discussing how it is the responsibility of each member of the team to ensure that there is an atmosphere conducive to self-care. It may be useful for teams to spend time together considering how they can create a self-caring atmosphere. Drawing from examples given by participants in this study, teams may want to think about areas such as expectations about leaving on time versus staying late, taking time to eat lunch together as a team, and facilitating honest conversations about wellbeing and coping.

4.2.3 Wider Systems Level

The participants also discussed how organisational factors can facilitate or hinder self-care. They noted the positive effects on self-care of feeling supported and valued, and the negative effects of consistently feeling under pressure. Building on the participants' criticism that their Trusts often do not support their self-care in the way that would like, employers might benefit from consulting with their employees about how they could support employees in creating a culture which is conducive to self-care. This suggestion is in line with an NHS England (2014) paper about compassionate leadership, which emphasised the need for organisations to listen to the experience of service users and staff, and to demonstrate to staff that they are valued by the wider organisation.

Having self-care discussed and modelled by supervisors and managers may increase perception that self-care is encouraged and allowed within services. Indeed, including self-care as a topic to discuss as part of supervision and appraisals may help to ensure that the facilitation of self-care remains on the agenda and is implemented in practice. Employees may benefit from working environments where employers provide time, space, and permission to self-care, as well as simple encouragement (Lee & Miller, 2013).

Importantly, however, it is imperative that responsibility for staff members' wellbeing is not individualised. The discussion of self-care must not be used in a way that blames staff for not coping with the increased pressures within the NHS, or used as justification for further increasing such pressures and expectations (Pakenham, 2015). The current privileging of outcomes and

efficiency within the NHS must be reviewed with regards to the effects that this emphasis seems to be having on staff wellbeing. As discussed, it is insufficient and ineffective to address 'coping with stress and distress' without addressing the underlying causes of the stress and distress (Grawitch et al., 2015)

4.3 Implications for Further Research

The findings of this study demonstrated that there appear to be multiple ways to understand self-care. This may explain the lack of consensus around self-care in the literature, discussed in chapter one. In this study, participants appeared to indicate that they understood self-care to be both as activities to do, and as a way to be. Participants did not appear to perceive a conflict in understanding self-care in both ways. However, it was not always clear whether or how participants understood the two perspectives of self-care to relate to one another, as is explored in section 4.1.3. Further research into these multiple understandings may help to clarify the concept of self-care. Other studies might consider presenting focus groups with questions enquiring about the relationship between self-caring activities and self-care as a way of being; it may be that the approach or stance taken towards the activity determines its self-caring effects, as suggested of both mindfulness and self-compassion (Richards et al., 2010; Yip et al., 2016).

Indeed, this study highlighted how mindfulness and self-compassion appear to be important to consider in the context of self-care, as participants discussed both self-compassion and mindfulness at length. This reflects the self-care literature, which draws on both self-compassion (e.g. Coleman et al., 2016; Wise et al., 2012) and mindfulness (e.g. Richards et al., 2010; Slonim et al., 2015). Participants did not draw neat conclusions about the relationship between the three concepts, which also reflects the literature; as discussed in section 1.5.1, the relationships between self-care, self-compassion, and mindfulness appear complex. Mindfulness has been found to moderate the effects of self-care (Di Benedetto & Swadling, 2014), while a self-compassionate stance has been proposed as a facilitator of self-care (Coleman et al., 2016). However, it has also been suggested that self-compassion may mediate the positive effects of mindfulness (Yip et al., 2016), yet both self-care

and mindfulness have also been proposed as integral parts of self-compassion (Neff, 2003; Sinclair et al., 2017). It was beyond the scope of this research to draw out the relationship between the concepts, however future research into this area may be able to explore this further.

The way participants spoke also indicated that one can take a proactive or reactive approach to self-care. Although the literature recommends proactive self-care (Norcross & Barnett, 2008; Wise et al., 2012), we must not automatically assume that a proactive approach is preferable. Evaluation of the most effective approaches to self-care have yet to be conducted, therefore, further research into this area may be of merit. The recent developments of the PSCS by Dorociak et al. (2017) and the SCBI by Santana and Fouad (2017) may support future research into self-care.

4.4 Critical Review

This section contains a critical evaluation of the study. Northcote's (2012) principles are used as a framework to evaluate the quality of the study. The generalisability of the findings and the implications of methodological choices are also discussed.

4.4.1 Quality Within Qualitative Research

As discussed in section 2.7, Northcote's (2012) guiding principles and criteria provide a basis for evaluating the nature and method of this study. The principles are: contributory, rigorous, defensible, credible, and affective. These considered in turn below, discussing how the present study sought to meet the principle.

4.4.1.1 Contributory

This relates to whether the study advances wider knowledge or understanding about the topic, and includes how being involved in the research may have benefitted the participants. This study sought to advance understanding of self-care, particularly in light of the summary of the literature in chapter one, which demonstrated that there is a lack of consensus about the topic. The study's findings are detailed in chapter three, and summarised in relation to the research questions in chapter four, where they are also related back to the

literature around self-care. An argument for the implications of these results both in research and practice is also presented, elucidating the practical, as well as theoretical contributions of the study.

In terms of participants, following the focus groups a number of participants anecdotally reported feeling that they benefitted from taking part: for example, participants spoke about how it was helpful to hear the similar experiences of others in their group, and commented that they valued the discussion in prompting them to think more deeply about their engagement in self-care.

4.4.1.2 Rigorous

This relates to the extent that the study's data collection, analysis, and interpretation are systemic and transparent. The data collection, analysis, interpretation and presentation is depicted in detail in chapter two, with the aim of openly demonstrating how this has been conducted in a systematic way. Throughout chapter three, the analysis and interpretations of the data are grounded in data excerpts from across the data set, through which the reader is enabled to make their own judgement on the data, its analysis, interpretation and presentation.

4.4.1.3 Defensible

This relates to whether the study utilises a strategy that is able to address the research questions. The research questions are presented in section 1.10.1, following a summary of existing research into self-care and gaps in the literature. Chapter two details the established qualitative research methods adopted, with a rationale given for the choices made. As well as providing a transparency in processes, this facilitates the reader to judge the extent to which these methods allow the research questions to be answered. Section 4.4.3 goes on to discuss how the research may have differed had a different analysis been adopted.

4.4.1.4 Credible

This relates to whether the study's findings are credible and supported by evidence, with plausible arguments about the significance of the evidence generated. The findings of the study are presented in chapter three, where the claims are grounded in data excerpts from across the focus groups. The reader

is thus enabled to come to their own conclusions on the claims made, which seek to present well founded and plausible arguments drawn from the data itself. Chapter two details the method by which the data was analysed in order to produce the conclusions.

4.4.1.5 Affective

This relates to the emotional involvement of both the participants and the researcher. As highlighted in section 2.6, a reflexive approach was taken towards the research, and informed the development, process, and reporting of the study. In line with this, a research journal was kept through the research process, which provided space to explore affect, emotional involvement and enthusiasm related to the research. Excerpts from the research journal can be seen in Appendix A. As previously mentioned, participants reflected positively on their experience of taking part in the focus groups. A reflexive review of the research is presented in section 4.5.

4.4.2 Generalisability

Sixteen participant took part in this study. Participants' demographics varied in terms of the number of years qualified, age, ethnicity, and service context. Although the sample was not balanced in terms of gender, with one quarter of participants being male, this reflects the unequal gender balance within therapeutic professions, and is similar to the gender balance of psychologists reported by the BPS (2016). As per the study's aims to explore the understanding and experience of therapists within the NHS, the sample was homogeneous with regards to participants being formally qualified therapists working in an NHS context. It is hoped that by recruiting from multiple services, three NHS Trusts, and two different areas of the UK, the study is likely to have avoided potential bias arising from characteristics of local services and their particular cultures.

However, despite being a typical sample size for a qualitative study of this nature, the relatively small sample size may limit the generalisability of the findings. Furthermore, the sample was self-selected, in that only those who expressed interest took part. This may have meant that the participants had a

particular interest in self-care, and therefore may understand or engage in self-care differently to others who have no interest in the topic.

It must also be considered that the groups took place in working hours, and those who took part were able to find the time for the focus group. A number of other potential participants expressed interest in taking part, but were unable to attend a focus group due to a lack of available time. This is particularly significant in considering that the focus group discussions touched on the participants' experiences of work pressures. Although the participants were clear that they felt under significant pressure at work, it may be that those who were unable to take part would have spoken about experiencing even more pressure.

Together, these may limit the generalisability of this study's findings. As this is the first study to research self-care in therapists working in NHS settings, further research into this topic would therefore be extremely valuable.

4.4.3 Epistemological and Methodological Reflexivity

Willig (2013) recommends reflection on the epistemological and methodological assumptions of a study, enabling consideration of what has been enhanced or obscured by the approach taken.

This study adopted a critical realist position, using this to inform the TA. By employing a critical realist approach, the study considered that the concept of self-care can be understood in multiple ways, but will be constrained by material reality. There is an acknowledgement that participants would be likely to take differing perspectives on self-care, informed by their own experience and culture. This approach was suited to the research aims of exploring how participants understand and engage in self-care, as well as what facilitates and hinders self-care.

However, the study could have been conducted in line with another stance, which is likely to have given the study's process, analysis and conclusions a different emphasis. For example, a social constructionist thematic analysis might have explored how the participants make sense of the concept of self-care in terms of the way it is socially construed. This analysis may have

focussed further on the way that self-care is spoken about within the NHS, and might have invited participants to be more critical about the concept of self-care.

4.5 Reflexive Review

The role of the researcher must be acknowledged as an integral part of qualitative research (Patton, 1990); reflexivity must be employed in a way that acknowledges the “institutional location of historical and personal aspects of the research relationship” (Parker, 2005, p. 25). In order to encourage a reflexive relationship with the research, a reflective journal was kept throughout the data collection and analysis. Extracts from the reflective journal can be seen in Appendix A. My personal and professional context, and some reflections are on the research process are presented below, with the aim of informing the reader about factors which are likely to have influenced my relationship with the data, and well as exploring how the data has influenced me.

4.5.1 My Understanding of Self-Care

I chose to research this area as I have personally experienced the benefit of self-care, particularly since working as an Assistant and Trainee Clinical Psychologist in NHS, where I have experienced first hand the pressures described by the participants in this study. I found the idea of researching what self-care actually *is* intriguing, as I found myself unable to come up with a coherent and sufficiently encompassing definition. Despite this, my own understanding of what self-care means to me is likely to have influenced the approach that I took to the development of the study, understanding of the literature, and interpretation of the results. My interest in developing a more compassionate approach to myself, as well as in compassion-focussed therapy (Gilbert, 2010), may have drawn my attention towards understandings of self-care that encompassed more than visible, measurable behaviours. My experience of trying to go for a run when feeling unwell, for example, has demonstrated to me that particular behaviours typically considered as self-care (doing exercise) may not always be self-caring in practice. Because of my interest in motivations and stances behind such behaviours, I may have

unintentionally privileged this understanding of self-care both during the focus group conversations, and in the analysis of the data.

Feeling able to relate to the participants' experiences of the pressures of working in the NHS may have also influenced my interpretation of the data. This could have led to me privilege a non-blaming approach towards therapists who find this pressure difficult to manage. As a result of this, I may have presented stronger conclusions about wider influences on self-care, rather than being drawn to focus on or prescribe particular actions that individuals 'should' take.

4.5.2 Power and Roles Within the Focus Groups

When conducting the focus groups, I noticed that at times I found it difficult to ensure the discussion remained related to the questions I was asking. I felt tension in wanting to encourage conversation between the participants themselves, while interjecting frequently enough to ensure that the conversation remained on topic. This appears to be a common challenge in conducting focus groups (Braun & Clarke, 2013), particularly for those who are new to facilitating focus groups, as I am. Reflecting on this as the focus groups progressed, I wondered if certain factors exacerbated the challenge I was experiencing in keeping participants on topic: that of my experience as a therapist, and my status as a trainee clinical psychologist. These factors are discussed further below.

I wonder if my experience of working as a therapist interacted with my skills as a researcher and focus group facilitator. I hope that my therapeutic skills and training gave me more confidence as a facilitator, and may have helped me to draw out participants' perspectives. However, I wonder if my experience also made it more likely that I would prioritise the participants' experience of the conversation, as I might with a client in therapy. During each of the focus groups discussions, I was pleased to notice that the participants appeared to be finding the discussion helpful. As well as being indicated by the way that participants were speaking, participants in a number of groups commented how helpful they found it to hear that others had similar experiences or emotions to their own. I noticed that when this happened, I was more likely to let participants carry on speaking, without bringing them back to the question I had asked. Reflecting on

this in my therapeutic journal, I reminded myself that the primary aim of the discussion was to provide data for the research. Although it remained a challenge, I feel that reflecting on this helped me to be more confident in bringing the discussion back to topic as the focus groups progressed.

I also wonder whether my status as a trainee clinical psychologist influenced the confidence I had in ensuring the focus groups discussion remained on topic. Outside of the context of the research, the participants held a higher status than I, as they were qualified clinicians, while I am a trainee. Although our context framed me as researcher and them as participants, my own tendency to associate more readily with the identity of a trainee clinical psychologist, rather than as a researcher, may have made it more difficult for me to take on the more powerful position and to direct the conversation assertively.

Use of the reflective journal helped me to be aware of these issues, and I perceive my skills in facilitating the discussions to have improved over the course of the focus groups. However, it may be that potential data was lost because of these challenges; as the focus groups were time limited, my delay in bringing participants back to focus on the question asked would have reduced the time available for other discussions.

4.5.3 My Relationship with Self-Care

It has been interesting to note my own relationship with self-care both before and during the completion of this study. My interest in and value of self-care is likely to be influenced by my experiences growing up. As well as being encouraged to work hard as a child, my family also encouraged me to take time off. As children, we were encouraged to spend time developing hobbies and interests, and to invest in meaningful relationships. I feel fortunate that my creative endeavours were celebrated, as well as my academic and professional accomplishments. I wonder if these experiences have supported me to develop an identity outside of the academic and professional arena, which has led me to place a value on self-care.

Completing this research has encouraged me to reflect on my own understanding and engagement in self-care. Using my research journal to keep note of my experiences, I was particularly struck by the discussion of self-

compassion and values in the focus group discussions. The discussion of self-compassion reinforced my own desire to develop a more self-compassionate attitude towards myself a part of my self-care. In terms of values, I found it particularly helpful to hear participants' framing their experiences of making values-based decisions as engagement in self-care. I was struck by the participants' descriptions of using their values to guide them in making decisions about the type of team they wanted to work in, the decisions they made about their career progression, and their experience of learning the importance of 'picking your battles' when working in the NHS. I hope to take this wisdom with me as I qualify as a psychologist.

However, despite my interest in and engagement with the topic of self-care, I have not been immune to the multiple challenges of completing doctoral level research in the context of training as a psychologist. The irony of spending my weekends and annual leave writing about self-care has not been lost on me, and on many occasions I have been grateful to those around me for facilitating (or enforcing) me to practice the very topic about which I have been writing.

4.6 Conclusion

This study aimed to explore how NHS therapists understand and engage in self-care, as well as the factors which facilitate and hinder self-care. Four focus groups were conducted with NHS psychologists and high intensity therapists, and the resulting data analysed using TA. The results reflected the literature in concluding that self-care is complex, and can be understood as multifaceted. The study added to the literature by suggesting that these facets may be understood as restorative activities, and ways of being. The relationship between such activities and ways of being was not explored, and would benefit from further study in future. In terms of approaches to self-care, the results of this study indicate that self-care can be proactive or reactive.

As well as contributing to the literature in terms of theoretical understanding of self-care in principle and practice, this study raised interesting questions about responsibility for self-care and psychological wellbeing. This study suggests that it may not be helpful to consider an individual's engagement in self-care in isolation of their context, due to numerous factors which can facilitate or hinder

self-care, including individual, relational, and systemic factors. Individual factors relates to one's own attitude or stance, relational factors relates to the influence of others' attitudes towards self-care, and systemic factors relates to the effect of pressure and expectations on self-care. The findings highlight the significant challenges of engaging in self-care in the context of the NHS, where pressures and expectations are high.

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APPENDIX A: RESEARCH JOURNAL

Reflections Following the Pilot Focus Group

They were very chatty, and getting them to talk was easier than I expected - maybe because i know them well? I tried asking two questions in one go at one point - that really didn't work, I will need to be careful to make sure my questions are short and clear in the real focus groups. Reflecting on how the groups went afterwards with the other trainees, we felt that it would be a good idea to switch round the first two areas, to talk more concretely first and more conceptually afterwards. I also noticed how much they had to say at the end which was really interesting - reflecting on the discussion and taking it in other directions, which made me think that it would be wise to leave a good amount of time for reflections in the focus groups. I'm concerned about fitting the discussion into an hour - I will have to be careful not to run over in the actual groups as participants might have appointments to get to straight after. I wonder if the focus groups will be as critical towards the concept of self-care? Perhaps not because we are so used to thinking critically about questions we are asked because of being in training (especially at UEL!).

Reflections Following Third Focus Group

I find it hard to interrupt people and direct conversation too much - especially when it seems that they are finding the conversation useful as a group. I think I forget that the aim is to contribute to my research, rather than what is helpful for them like in normal therapy. I also find I have to think so carefully about my words so I'm using their words back to them, rather than helping them to make links between things like I might in therapy.

I found this one a bit harder to stick to time to make sure we had enough time for reflections at the end. I realised what a shame that was afterwards, because three of the participants stuck around to catch up and have a chat, and said some really interesting things about self-care but I can't use it in my data because the focus group had formally ended. In the next one I need to be a bit better with making sure I stick to time so we get enough time to reflect at the

end. They seemed to find the group especially useful though, and mentioned afterwards that it prompted them to consider setting up a regular group to connect and talk about things like this, so that felt really positive.

Reflections During Analysis

I'm finding the analysis more difficult than I expected. I understand what they mean now when they say that you have to be immersed in the data and why they suggest you give such a long time to do it! Currently it feels a bit more like drowning than immersion, but I found it really helpful to talk through my ideas with a friend and have her reflect back to me what I was saying. I think that helped me to start to see patterns across the data, rather than just following my initial temptation to make categories of different self-care and try to literally summarise every self-care activity/mindset that participants referenced.

I find it quite anxiety provoking as I'm so worried about losing something important that someone has said. I'm also quite aware of my own perspective of thinking that self-care has to be about more than just individual behaviours, and I wonder if that is making me privilege some things in the data such as the discussion of self-compassion. It feels so different from doing statistical analysis when it's easier to get an idea if you're doing something 'right' or 'wrong'!

APPENDIX B: UEL ETHICAL APPROVAL APPLICATION

UNIVERSITY OF EAST LONDON

School of Psychology

**APPLICATION FOR RESEARCH ETHICS APPROVAL
FOR RESEARCH INVOLVING HUMAN PARTICIPANTS**

FOR BSc RESEARCH

FOR MSc/MA RESEARCH

**FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL,
COUNSELLING & EDUCATIONAL PSYCHOLOGY**

*Students doing a Professional Doctorate in Occupational & Organisational Psychology and PhD candidates should apply for research ethics approval through the University Research Ethics Committee (UREC) and not use this form. Go to:

<http://www.uel.ac.uk/gradschool/ethics/>

If you need to apply to have ethical clearance from another Research Ethics Committee (e.g. NRES, HRA through IRIS) you DO NOT need to apply to the School of Psychology for ethical clearance also.

Please see details on www.uel.ac.uk/gradschool/ethics/external-committees.

Among other things this site will tell you about UEL sponsorship

Note that you do not need NHS ethics approval if collecting data from NHS staff except where the confidentiality of NHS patients could be compromised.

Before completing this application please familiarise yourself with:

The *Code of Human Research Ethics* (2014) published by the British Psychological Society (BPS). This can be found in the Ethics folder in the Psychology Noticeboard (Moodle) and also on the BPS website http://www.bps.org.uk/system/files/Public%20files/code_of_human_research_ethics_dec_2014_inf180_web.pdf

And please also see the UEL Code of Practice for Research Ethics (2015)

<http://www.uel.ac.uk/gradschool/ethics/>

HOW TO COMPLETE & SUBMIT THIS APPLICATION

1. Complete this application form electronically, fully and accurately.
2. Type your name in the 'student's signature' section (5.1).
3. Include copies of all necessary attachments in the **ONE DOCUMENT SAVED AS .doc** (See page 2)
4. Email your supervisor the completed application and all attachments as **ONE DOCUMENT**. INDICATE 'ETHICS SUBMISSION' IN THE SUBJECT FIELD OF THIS EMAIL so your supervisor can readily identify its content. Your supervisor will then look over your application.
5. When your application demonstrates sound ethical protocol your supervisor will type in his/her name in the 'supervisor's signature' section (5.2) and submit your application for review (psychology.ethics@uel.ac.uk). You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this.
6. Your supervisor should let you know the outcome of your application.
Recruitment and data collection are **NOT** to commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (See 4.1)

ATTACHMENTS YOU MUST ATTACH TO THIS APPLICATION

1. A copy of the invitation letter that you intend giving to potential participants.
2. A copy of the consent form that you intend giving to participants.
3. A copy of the debrief letter you intend to give participants (see 23 below)

OTHER ATTACHMENTS (AS APPROPRIATE)

- A copy of original and/or pre-existing questionnaire(s) and test(s) you intend to use.
- Example of the kinds of interview questions you intend to ask participants.
- Copies of the visual material(s) you intend showing participants.
- A copy of ethical clearance or permission from an external organisation if

you need it (e.g. a charity or school or employer etc.). Permissions must be attached to this application but your ethics application can be submitted to the School of Psychology before ethical approval is obtained from another organisation if separate ethical clearance from another organisation is required (see Section 4).

Disclosure and Barring Service (DBS) certificates:

- **FOR BSc/MSc/MA STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** A scanned copy of a current Disclosure and Barring Service (DBS) certificate. A current certificate is one that is not older than six months. This is necessary if your research involves young people (anyone 16 years of age or under) or vulnerable adults (see Section 4 for a broad definition of this). A DBS certificate that you have obtained through an organisation you work for is acceptable as long as it is current. If you do not have a current DBS certificate, but need one for your research, you can apply for one through the HUB and the School will pay the cost.

If you need to attach a copy of a DBS certificate to your ethics application but would like to keep it confidential please email a scanned copy of the certificate directly to Dr Mary Spiller (Chair of the School Research Ethics Committee) at m.j.spiller@uel.ac.uk

- **FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** DBS clearance is necessary if your research involves young people (anyone under 16 years of age) or vulnerable adults (see 4.2 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is sufficient and you will not have to apply for another in order to conduct research with vulnerable populations.

Your details

1. Your name:

Sarah Morris

2. Your supervisor's name:

Dr Katy Berg

3. Title of your programme: (e.g. BSc Psychology)

Professional Doctorate in Clinical Psychology

4. Title of your proposed research: (This can be a working title)

How do Clinical Psychologists understand and engage in self-care

5. Submission date for your BSc/MSc/MA research:

May 2018

6. Please tick if your application includes a copy of a DBS certificate

n/a

7. Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Mary Spiller for confidentiality reasons

(Chair of the School Research Ethics Committee) (m.j.spiller@uel.ac.uk)

n/a

8. Please tick to confirm that you have read and understood the British Psychological Society's Code of Human Research Ethics (2014) and the UEL Code of Practice for Research Ethics (See links on page 1)



2. About the research

9. The aim(s) of your research:

To explore how Clinical Psychologists understand self-care.

To explore how Clinical Psychologists engage in self-care.

To explore what facilitates self-care

To explore what hinders self-care

10. Likely duration of the data collection from intended starting to finishing date:

April 2017 - August 2018

Methods

11. Design of the research:

This study will use the qualitative methodology of Thematic Analysis. This will involve use of focus groups and one-to-one interviews, asking questions related the research questions. These will be transcribed, and the transcripts analysed in line with Thematic Analysis methodology.

An interview schedule with additional prompts will be used to facilitate discussion in the focus groups and interviews. Focus groups will last between 60 and 90 minutes, while interviews will last up to 60 minutes. The focus groups/interviews will be conducted in the UK on NHS premises.

12. The sample/participants:

Qualified Clinical Psychologists and High Intensity therapists working in the NHS will be invited to attend focus groups or one-to-one interviews. It is anticipated that three focus groups with 4-8 participants will be conducted. Additional one-to-one interviews will be used should recruitment for focus groups provide insufficient numbers of participants.

Recruitment will take place through contacts known to the researcher and/or supervisor.

13. Measures, materials or equipment:

An interview schedule will be used for focus groups and interviews (see attached interview schedule). An audio-recorder will be used to record interviews and facilitate transcription onto a password protected computer, where transcripts will be stored.

14. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

YES / NO / **NA**

15. Outline the data collection procedure involved in your research:

- Consent for recruitment will be sought from the NHS Trust Research and Development Department, and the NHS Research Health Authority, as well as the specific service from which participants will be recruited.
- NHS services will be contacted through contacts known to the researcher/ research supervisor.
- Once permission for recruitment is granted, an information sheet about the study will be distributed to qualified Clinical Psychologists/High Intensity

workers within the service.

- Those who agree to participate will be invited to attend and given a consent form to read and sign if they wish to proceed with the focus group/interview.
- Focus groups will last for 60-90 minutes, while interviews will last for up to 60 minutes. Both will only commence after the consent form is signed.
- Focus groups/interviews will be audio-recorded and transcribed for analysis within three months by the researcher.
- Focus groups/interviews will take place in a quiet room on NHS premises.

3. Ethical considerations

Please describe how each of the ethical considerations below will be addressed:

16. Fully informing participants about the research (and parents/guardians if necessary):

Potential participants will be given an information sheet about the research. They will also be invited to get in touch with the researcher by email with any questions prior to the focus group/interview. Opportunity for further questions and discussion about the research will be given before focus groups/interviews begin. They will also be reminded that they are free to take a break at any time or to withdraw their data without giving a reason.

17. Obtaining fully informed consent from participants (and from parents/guardians if necessary):

Participants will be given a consent form prior to the focus group/interview. There will be opportunity to discuss any concerns or queries with the researcher before the focus group/interview commences.

18. Engaging in deception, if relevant:

The proposed research involves no deception.

19. Right of withdrawal:

Participants will be advised of their right to withdraw from the research study at any time without disadvantage to them and without being obliged to provide any reason. After focus groups/interviews have taken place, participants will be asked if they are happy for their data to be included in the study, and reminded of their right to withdraw their data. All reporting of all

participants' data will be anonymised. This will be made clear in both the information sheet and consent form.

20. Anonymity & confidentiality: (Please answer the following questions)

20.1. Will the data be gathered anonymously?

YES / **NO**

21. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

- Names and contact details of participants will be kept separately from all other data, and will be kept on a password protected computer.
- Names and all identifying references will be changed in transcripts and in all reporting of the data.
- Audio-recordings will be transcribed only by the researcher. Transcriptions will be kept on a password protected computer.
- Audio-recordings, names and contact details will be destroyed after examination.
- Anonymised transcripts will be kept for three years after the study and then deleted.
- Anonymised transcripts will be read only by the researcher, research supervisor and examiners.
- Participants will be made aware of all of the above through the information sheet and on the consent form.

22. Protection of participants:

There are no potential hazards or risks of injury or accident to participants. Although questions do not relate to topics that are likely to be experienced as highly sensitive in nature, participants may become upset if they talk about something that is upsetting or emotional. Should this occur, participants will be spoken to individually after the focus group or interview; it will be recommended that participants speak to their line manager, supervisor or Occupational Health Department if they are concerned about their own self-care. Participants will also be reminded prior to the group/interview of their right to withdraw at any time without giving a reason. Debrief sheets will be provided to all participants.

23. Protection of the researcher:

There are no specific risks to the researcher. Focus groups/interviews will be conducted on NHS premises and the research supervisor will be aware of the times of focus groups/interviews.

24. Debriefing participants:

Participants will be given time at the end of the group/interview to ask any questions, and will be given a debrief form. Participants will be reminded of what will happen to the data and given opportunity to withdraw their data from the study. There is no deception involved at any point.

25. Will participants be paid? YES / **NO**

26. Other:

n/a

4. Other permissions and ethical clearances

27. Is permission required from an external institution/organisation (e.g. a school, charity, local authority)?

YES / **NO**

28. Is ethical clearance required from any other ethics committee?

YES / **NO**

29. Will your research involve working with children or vulnerable adults?*

YES / **NO**

30. Will you be collecting data overseas?

YES / **NO**

5. Signatures

TYPED NAMES ARE ACCEPTED AS SIGNATURES

Declaration by student:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name: Sarah Morris

Student's number: u1525468

Date: 4/2/17

Declaration by supervisor:

I confirm that, in my opinion, the proposed study constitutes a suitable test of the research question and is both feasible and ethical.

Supervisor's name: Katy Berg

Date: 23/2/17

APPENDIX C: UEL ETHICAL APPROVAL CONFIRMATION

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates

REVIEWER: Dr Florentina Hadjiefthyvoulou

SUPERVISOR: Dr Katy Berg

COURSE: Professional Doctorate in Clinical Psychology

STUDENT: Sarah Morris

TITLE OF PROPOSED STUDY: How do Clinical Psychologists understand and engage in self-care

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.
3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

Approved with minor suggestions

Minor amendments required (for reviewer):

-might be a good idea to specify a date for data withdrawal in the information sheet and debrief
-in the ethics form you say NO to question 27 whether permission from an external organisation is required. I think you might need to get some sort of permission from NHS if you are interviewing employees at their place of work. So discuss how you will do this with

your supervisor. There is some mention of it in the ethics form but make sure you are clear of what sort of permission you need before your interviews and focus groups

Major amendments required (for reviewer):

ASSESSMENT OF RISK TO RESEARCHER (for reviewer)

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

<input type="checkbox"/>	HIGH
<input type="checkbox"/>	MEDIUM
<input checked="" type="checkbox"/>	LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer (Typed name to act as signature): Florentia Hadjiefthymioulou

Date: 1/03/17

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

Confirmation of making the above minor amendments (for students):

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name (Typed name to act as signature): Sarah Morris
Student number: u1525468

Date: 5.3.17

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: <http://www.uel.ac.uk/gradschool/ethics/fieldwork/>

APPENDIX D: HRA ETHICAL APPROVAL CONFIRMATION



Health Research Authority

Mrs Sarah Morris

[Address]

Email: hra.approval@nhs.net

06 June 2017

Dear Mrs Morris,

Letter of HRA Approval

Study title:	How do Psychologists and High Intensity Therapists understand and engage in self-care?
IRAS project ID:	229055
REC reference:	18/HRA/0121
Sponsor	University of East London

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document “*After Ethical Review – guidance for sponsors and investigators*”, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the [HRA website](http://www.hra.nhs.uk/hra-approval), and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the [HRA website](http://www.hra.nhs.uk/hra-approval).

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application

IRAS project ID	229055
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procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

Your IRAS project ID is **229055**. Please quote this on all correspondence.

Yours sincerely

Juliana Araujo

Assessor

Email: hra.approval@nhs.net

Copy to:



Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity]		11 May 2017
IRAS Application Form [IRAS_Form_24052017]		24 May 2017
Other [UEL ethics approval]	1	11 May 2017
Other [Statement of Activities]	2.0	06 June 2017
Other [UEL ethics application]	1	11 May 2017
Other [Schedule of Events (Dated)]	1.0	26 May 2017
Participant consent form [Informed Consent Form]	v.2.0	01 June 2017
Participant information sheet (PIS) [Participant Information Sheet]	v.2.0	01 June 2017
Referee's report or other scientific critique report [Peer review - Research proposal feedback]		11 May 2017
Research protocol or project proposal [Research Proposal]	v.2.0	01 June 2017
Summary CV for Chief Investigator (CI) [Investigator CV]		11 May 2017
Summary CV for supervisor (student research) [Supervisor CV]		11 May 2017
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Protocol summary]	1	11 May 2017

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations, capacity and capability and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: Dr Mark Finn

Tel: [REDACTED]

Email: [REDACTED]

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards?	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The Statement of Activities will form the agreement between the sponsor and the sites.
4.2	Insurance/indemnity arrangements assessed	Yes	<p>The sponsor will provide insurance coverage for the study.</p> <p>Insurance certificate has been submitted.</p> <p>Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study</p>
4.3	Financial arrangements assessed	Yes	<p>No funding application was made.</p> <p>The Statement of Activities indicates that no funds or resources will be allocated to the sites.</p>
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments

Section	HRA Assessment Criteria	Compliant with Standards?	Comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	The study does not require NHS Research Ethics Committee review
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

There are two NHS participating organisations of the same type.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If Chief Investigators, sponsors or Principal Investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the Chief Investigator, sponsor or Principal Investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

Participating NHS organisations in England **will be expected to formally confirm their capacity and capability** to host this research.

- The sponsor should ensure that participating NHS organisations are provided with a copy of this letter and all relevant study documentation, and work jointly with NHS organisations to arrange capacity and capability whilst the HRA assessment is ongoing.
- Further detail on how capacity and capability will be confirmed by participating NHS organisations, following issue of the Letter of HRA Approval, is provided in the *Participating NHS Organisations and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections of this appendix.
- The [Assessing, Arranging, and Confirming](#) document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

Principal Investigator Suitability

This confirms whether the sponsor's position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England, and the minimum expectations for education, training and experience that PIs should meet (where applicable).

The Chief Investigator will be responsible for all research activities at the NHS organisations. No local Principal Investigator is expected.

GCP training is not a generic training expectation, in line with the [HRA statement on training expectations](#).

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken.

As the research involves staff being interviewed at NHS organisations in non-clinical areas no further access arrangements are expected.

The researcher is expected to work under off-site working policies and procedures of their employing organisation.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England in study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

APPENDIX E: HRA AMMENDMENT CONFIRMATION

From: AMENDMENTS, Hra (HEALTH RESEARCH AUTHORITY) hra.amendments@nhs.net
Subject: IRAS 229055. Amendment acknowledgement and implementation information
Date: 27 July 2017 at 08:25
To: Sarah MORRIS
Cc: [REDACTED]

HA

Dear Sarah Morris,

Thank you for submitting an amendment to add one or more new sites to your project

If you have listed new sites in any other UK nations we will forward the information to the national coordinating function(s) for nations where the new site(s) are being added. In Northern Ireland, Scotland and Wales, NHS/HSC R&D offices will be informed.

What Happens Next?

Please set up the new site(s) as per the guidance found within [IRAS](#). **Please note** that processes change from time to time so please use the most up to date guidance about site set up.

If your study is supported by a research network, please contact the network as early as possible to help support set up of the new site(s).

IRAS Project ID:	229055
Short Study Title:	How do Psychologists and HITs understand and engage in self care?
Date complete amendment submission received:	24/07/2017
Sponsor Amendment Reference Number:	New site
Sponsor Amendment Date:	24/07/2017
Amendment Type	Non-substantial
For new sites in Northern Ireland, Scotland and/or Wales only:	Please start to set up your new sites. Sites may not open until NHS management permission is in place.
For new sites in England only:	<p>For studies which already have HRA Approval: This email also constitutes HRA Approval for the amendment, and you should not expect anything further from the HRA. Please start to set up your new sites. Sites may not open until the site has confirmed capacity and capability (where applicable).</p> <p>For studies which do not yet have HRA Approval: HRA Approval is pending and you will receive confirmation of HRA Approval. You can start the process of setting up the new site but cannot open the study at the site until HRA Approval is in place and the site has confirmed capacity and capability (where applicable).</p>

If you have any questions relating to setting up sites in England, please direct these to hra.approval@nhs.net.

If you have any questions relating to setting up sites in Northern Ireland, Scotland or Wales, please direct these to the relevant [national coordinating function](#).

Note: you may only implement changes described in the amendment notice.

Please do not hesitate to contact me if you require further information.

Kind regards

Amendment Co-ordinator

Health Research Authority



The Old Chapel | Royal Standard Place | Nottingham | NG1 6FS



T. 020 7104 8096


E. hra.amendments@nhs.net


W. www.hra.nhs.uk


APPENDIX F: R&D APPROVAL





 Inbox - UEL 5 December 2017 at 10:39 


 [Details](#)

IRAS: 229055- Local AAC review complete at 

To:  & 5 more


Dear 


RE: IRAS [229055](#) Confirmation of Capacity and Capability at 


 Trust.

Full Study Title: [How do Psychologists and High Intensity Therapists understand and engage in self-care?](#)

Latest HRA Approval Date: [6 June 2017](#)

Site PI/LC: 

This email confirms that  Trust has the capacity and capability to deliver the above referenced study. Please find attached the signed agreement as confirmation.


 Trust agrees to start this study on a date to be agreed when you as sponsor give the green light to begin. Please ensure the R&D office and local CRN contacts are provided with this date.


If you wish to discuss further, please do not hesitate to contact us.

As specified in the HRA Approval, Letters of Access for the research team are not considered necessary .

Please note, in line with national HRA approvals process, you will no longer receive an NHS R&D Approval/Permission letter.

Kind regards,



On behalf of  Trust

[Redacted]

20 June 2017 at 10:19



IRAS: 229055 - Confirmation of [Redacted] capacity and Capability

[Details](#)

To: Sarah MORRIS, Cc: [Redacted]

Dear Sarah Morris,

Study title: How do Psychologists and High Intensity Therapists understand and engage in self-care?
IRAS project ID: 229055
Ethics Ref: 18/HRA/0121

Sponsor: University of East London

I am writing to confirm capacity and capability for the above titled research to proceed at [Redacted] Trust.

This confirmation is based on the HRA approval letter dated 6th June 2017 and the attached Statement of Activities and corresponding appendix B. The study is considered to be commencing at [Redacted] today 20th June 2017.

I am delighted to also attach your letter of access to this email. You should inform [Redacted] (Research Data Manager) when your study has completed so that we can provide you with a close out monitoring form for return. I have copied [Redacted] here for your convenience and interim monitoring purposes.

Should you have any other queries regarding the research here at [Redacted] please do feel free to contact me. We wish you every success with your work here at the Trust.

Kind regards,

[Redacted]

Research and Development Administrator
Research and Development Department

[Redacted]

Dear Sarah

NHS Confirmation of Capacity and Capability at [REDACTED] Trust

Short Title:	How do psychologists and HITs understand and engage in self-care?
IRAS ID.:	229055
R&D ID.:	CHC0150/RS
Principal Investigator:	Sarah Morris

This email confirms that [REDACTED] Trust has the capacity and capability to deliver the above referenced study. Please find attached our agreed Statement of Activities as confirmation.

We agree to start this study on a date to be agreed when you as Sponsor give the green light to begin.

NHS Confirmation of Capacity and Capability for the above research has been granted on the basis described in the HRA approval application. The documents received are:

Document	Version	Date
Protocol	2.0	01/06/2017
Protocol Summary	1.0	11/05/2017
Participant Information Sheet	2.0	01/06/2017
Participant Consent Form	2.0	01/06/2017
IRAS Form		24/05/2017
Evidence of Insurance		09/08/2017
UEL Ethics Approval		11/05/2017
HRA Approval		06/06/2017

For further information regarding how to notify us of any amendments to the study please refer to the [Amendments Guidance for Researchers](#).

If you wish to discuss this further, please do not hesitate to contact me.
Kind regards

[REDACTED]



APPENDIX G: INFORMATION SHEET

[Trust logo]



UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London
E15 4LZ

The Principal Investigator:

Sarah Morris

[email address]

Invitation to participate in a research study

I'd like to invite you to participate in a research study which is being conducted as part of my Doctorate in Clinical Psychology at the University of East London.

Project Title

How do Psychologists and High Intensity Therapists understand and engage in self-care?

Project Description

The aim of the research is to explore how Psychologists and High Intensity Therapists understand and engage in self-care. This research will form the basis of my thesis, and may be used for additional articles or publications.

The research involves focus groups with professionals delivering psychological interventions in an NHS context. If you chose to take part, you will be invited to discuss your understanding of self-care, describe how you engage in self-care, and to discuss what factors facilitate and hinder self-

care. There are no known risks or dangers involved in taking part, although it is possible you might get upset should you choose to talk about something difficult or emotional. There will be an opportunity to debrief following the discussion.

Confidentiality of Data

Discussions will be confidential, unless information is disclosed that indicates risk to staff or service users. In this case, the information would be passed on to the service manager with the participant's involvement. There is an expectation that all participants will maintain confidentiality regarding other participants' participation and contribution to the discussion.

I will facilitate and transcribe the focus groups, which will be recorded on a digital recorder. All names and identifiable information will be anonymised in transcripts and quotations used in the write up of the research. The transcripts may be read by my supervisor at the University of East London, as well as examiners assessing the thesis. The audio file and transcript will be saved on a computer that is password protected, in line with the University of East London's data protection policies. Audio recordings will be deleted following my examination. The transcripts will be deleted after three years.

Location

Focus groups will take place at your place of work.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. Should you choose to participate, you are free to withdraw at any time without disadvantage to yourself and without giving a reason. After the focus group has taken place you will be given the option to remove all or part of your data from the study. Requests for withdrawal of data will be possible for two weeks following the focus group.

The IRAS project identification number is 229055. Indemnity cover is provided by Zurich Municipal. Please contact me by email if you have any

questions or would like to discuss this study further, or if you would like a copy of the Indemnity certificate.

If you have any questions or concerns about how the study has been conducted, please contact my supervisor: Dr Katy Berg, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: [telephone number]. Email: [email address])

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: [telephone number]. Email: [email address])

Thank you in anticipation.

Yours sincerely,

Sarah Morris

APPENDIX H: CONSENT FORM

[Trust logo]



UNIVERSITY OF EAST LONDON **Consent to participate in a research study**

How do Psychologists and High Intensity Therapists understand and engage in self-care?

IRAS project identification number: 229055

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential, unless information is disclosed that indicates risk to staff or service users. In this case, the information would be passed on to the service manager with the participant's involvement. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that my anonymous data will be used in the write-up of the study and in any further analysis that may be conducted by the researcher, unless I choose to withdraw my data. I understand that it will only be possible to remove data for the two weeks following the focus group.

Participant's Name (CAPITALS)

Participant's Signature

Researcher's Name

Researcher's Signature

Date:

APPENDIX I: DEBRIEF SHEET

[Trust logo]



UNIVERSITY OF EAST LONDON

Debrief sheet

How do Psychologists and High Intensity Therapists understand and engage in self-care?

Thank you for participating in this study about how Psychologists and High Intensity Therapists understand and engage in self-care. As discussed, the recording of our conversation will be transcribed, analysed and written up as part of my Professional Doctorate in Clinical Psychology. All identifying information will be removed from transcripts and subsequent reporting of the data.

If taking part in this study caused you to be concerned about your wellbeing or self-care, we would recommend speaking to your line manager, supervisor or Occupational Health Department.

Please provide your email address if you would like a summary of findings on completion of the research.

Yours sincerely,

Sarah Morris

[email address]

APPENDIX J: DEMOGRAPHICS FORM

Self-care focus group demographics form

Gender:

Age:

Ethnicity:

Role: (please circle)

Clinical Psychologist
Therapist

Counselling Psychologist

High Intensity

Other:

APPENDIX K: INTERVIEW SCHEDULE

Introductions and engagement

Reiterate consent, confidentiality and option to withdraw at any time. Remind participants that they are welcome to take a break at any time. Agree approximate time of group/interview, and ask participants to introduce themselves by the name they would like to be known.

Questions

- Do you engage in self-care? If so, what does that look like for you?
 - Are there other ways which you engage in self-care that we haven't covered?
- What does the term self-care mean to you?
 - What would you consider to be self-care?
 - What is it about that that makes it seem like self-care for you?
- In your experience, what facilitates and hinders self-care?
 - What makes it harder or easier to engage in self-care?
 - What gets in the way of engaging in self-care?
 - Do certain attitudes make it more or less likely that you will engage in self-care (own, others, messages from home or work environment)
 - Do aspects of your work environment make it easier or more difficult to engage in self-care?
 - What would make it more/less likely that you would engage in self-care at work or more generally?

Closing

- Do you have any other thoughts or views that you would like to share?
- Has the discussion today made you think about self-care differently – in what way?

Debriefing

Draw discussion to a close and thank participants for their contribution.

Reiterate confidentiality. Remind participants that they are welcome to speak to

me if they have any questions or concerns about the project, or if they would like to withdraw their data. Suggest participants speak to their supervisor/line manager/Occupational Health department if they have concerns about their own wellbeing or self-care.

Sample prompts

Could you say more about that? What is/was that like? How did you come to that conclusion? Can you give me an example? What effects does that have? Do others here agree? Has that also been your experience? Does anyone else have thoughts about that? How does that relate to self-care?

APPENDIX L: ANNOTATED TRANSCRIPT EXAMPLE

386

387 Sarah: Mmm. Thinking a bit more conceptually, what does the self - err, what

388 does the term self-care actually mean to you?

389

390 April: It means, for me, taking myself away from the work enough to ensure

391 that I'm not overtaken by it. Umm, yeah. And also, like when I am at work, a

392 space to reflect.

393

394 Emma: I think often, building on that, I totally agree with that, and that

395 sometimes for me it's also about knowing when I am being a bit overtaken by

396 it. And thinking what do I need to do? Is this something that just needs a chat

397 in supervision and I'll feel immediately better about it? Or is it something that I

398 need to do something about, like - moving to a different job, or, you know,

399 something more than you need to talk to a manager about.

400

401 April: It's about noticing. It's important when it's (unintelligible) something like

402 to much.

403

404 Emma: And when, certainly sometimes when I've noticed only looking back

405 when my behaviour has changed over a week or so, and I think 'ooh, yeah

406 the work is really getting to me this week, what am I going to do about it next

407 week to make sure that this isn't it - I don't want my life to be like that. I don't

408 want the job to start consuming the bits of my life outside of the job.

409

410 April: What was the question again?

411

412 Sarah: So, what, kind of, what are we actually talking about when we're

413 talking about self-care? What does it mean?

414

415 Yasmin: Well, sort of self-compassion as well, isn't it really. Being kind to

416 yourself, in some way. Nurturing coming to mind, those sorts of terms. Umm -

417 so nurturing, compassion. And just, you know, having, I mean it relates to

418 what, what you've both been saying really, but having, s - some sort of space

419 to reflect, and being err, able to know - that you can - just notice in yourself,

420 really isn't it. It's noticing that you are there, you are important and that you

FG2

12 of 18

separate

space away from work

space to reflect

Awareness & needs

noticing

Reflecting

Job impacts wellbeing

self-compassion

sc as nurture

APPENDIX M: CODED TRANSCRIPT EXTRACT

656	Sue: And I think we've become a very materialistic nation, er, where we're	
657	wasting so much stuff So I'm starting to contemplate all of that.	
658		
659	Sarah: And how does that link to self-care for you?	
660		
661	Sue: I think, the word Ed used - existentialism, and it's that, that none of it	Sarah MORRIS Sense of perspective
662	goes with you. And umm, self-care about journeying towards a, umm, a life	
663	where you look back whether, you know, you're going die tomorrow, or in 35	
664	years' time, which in my family it could be tomorrow, it might be in 35 years'	
665	time. Err, what kind of legacy or, or - kind of - I can't think what the word is, so	Sarah MORRIS Living according to one's values
666	I'm gonna use the word thing, which is never a good thing. What kind of	
667	memory or thing are you going to leave behind? And actually, I want to tread	
668	gently on the world. And so the self-care in that is to not care just for me, but	
669	to think about the planet, and everything in between, individuals and the	
670	planet.	
671		
672	Sarah: So the care isn't just for you?	
673		
674	Sue: It isn't. I don't believe self-care is just about an individual, erm, it's like	
675	the pebble in the pond isn't it. Whatever you do, it ripples to the edge of the	
676	pond and back.	
677		
678	Mia: But I think that becomes quite tricky though, I mean, what you were	Sarah MORRIS Balance own and others' needs
679	saying Alice about kind of - and you were saying about protecting yourself,	
680	but at the same time, I go to toddler groups and things, and it's kind of being	Sarah MORRIS Boundaries in relationships
681	mindful about how many conversations I actually engage in about their child's	
682	problems! You know, err, not wanting to hear information about their work,	Sarah MORRIS Concern for others' wellbeing
683	hoping people don't start asking me questions about different things. But also	Sarah MORRIS Knowing values
684	thinking about ok, you know the meaning in life is really, is a really big thing	
685	for me. And part of that, I want my family and my friends to be well, and	
686	sometimes about facilitating that sometimes. Umm.	
687		
688	Sarah: So how does that relate to your self-care?	
689		

690	Mia: I guess, you know, when you feel that you've contributed to wellbeing,	Sarah MORRIS Balance own and others' needs
691	like my sister's been having a bit of a health problem. Umm, and that meant	Sarah MORRIS Concern for others' wellbeing
692	she had to go for lots of investigations, scans, blood tests every couple of	
693	days, and she found it really, really hard. They're not sure, and they're still not	
694	sure what that's about, umm, and my mum was really worried, and umm, you	
695	know, it's about supporting her. It kind of makes me feel like err, it's important	
696	for me that she's well, so that meant I'm spending extra time talking to her,	
697	and supporting her through the journey that she's going on, and it makes me	
698	feel like a better human being. It's not necessarily selfish, cus I actually care	Sarah MORRIS Knowing values
699	about her, I want her to, to be well. But I think it goes to my value system,	
700	family and that are important, and their wellbeing is important.	
701		
702	Sarah: You talk about values there. How do values relate to self-care? I'm not	
703	just asking you, Mia.	
704		Sarah MORRIS Balancing priorities
705	Mia: No, but for example, like if I'm stressed or going through things I will	Sarah MORRIS Balance own and others' needs
706	prioritise my family, my closest friends, and maybe not really make a huge	
707	effort to make new friends, or you know, engage in conversation with people I	
708	don't know particularly well. Umm. Perhaps that limits you in some way,	
709	because perhaps you miss a lot, but you know, that's, I feel that's what I have	
710	to do.	
711		
712	Ed: And I suppose I'm just thinking about this, there's this gap between sort of	
713	ideal self and perceived self, isn't it. And I think you know the big, I, I, I feel	Sarah MORRIS Work as toxic
714	there's quite a big gap for me right now, and I think umm, I suppose I'm sitting	
715	here as well thinking all these kind of ingredients in making a good life, I feel	
716	like work's a big part of that, or should have been a big part of that shouldn't	Sarah MORRIS Managing effects of work
717	it. And I think actually we've started talking about this thing as having become	
718	really toxic in our lives and we've got to manage it in our lives. Whereas I'm	Sarah MORRIS Challenges of working in the NHS
719	sure that's not why we came here, you know, I think the psychology bit is	
720	really fulfilling and I really enjoy that. I just think doing that in the NHS is just	Sarah MORRIS Self-care is not enough to manage NHS working
721	dreadful. And I think it's an absolute negative. If that makes sense, so I think	
722	actually. So I think actually, something that should add to this sense of	
723	wellbeing I think actually needs to be really kind of, managed and sort of	
724	detoxed, detoxed in other bits of my life really.	

APPENDIX N: LIST OF CODES

Activities - cooking/eating	Energy vs depletion
Aesthetics of the environment	Ethical responsibility to self-care
Ambivalence about the term 'self-care'	Ethos of department affects self-care
Attention	Feeling supported and cared for
Availability of supportive others	Feeling valued at work
Available time for reflection	Finding a sense of balance
Awareness of own needs	Finding a work environment that suits you
Balancing own and others' needs	Finding work meaningful and rewarding
Balancing priorities	Fragmented services in NHS
Balancing resources and demands	Guilt about self-care
Being able to switch off	Hobbies
Being authentic at work	Immediate rewards of self-care
Body as a communicator of needs	Intentional self-care
Boom and bust pattern of self-care	Knowing own capacity
Boundaries in activities/time	Knowing stressors
Boundaries in relationships	Knowing values
Burnout	Label of self-care
Challenges of MDT working	Lack of opportunity for self-care at work
Concern for others' wellbeing	Lack of understanding about therapeutic work from managers/MDT
Connecting with nature	Legitimacy of self-care
Connecting with others	Living according to one's values
Cuts/changes to services	Maintaining enthusiasm for therapeutic work
Different professions' value of self-care	Maintaining interest in job
Effect of leadership and management	Managing effects of stress with self-care
Effects of not engaging in self-care	Managing others' expectations
Effects of therapeutic work	Managing stress
Emphasis on efficiency in NHS	Managing work demands

Maslow's hierarchy of needs	Sacrificing career progression for quality of life
Meeting own needs	Self-awareness
Mindfulness	Self-care as a part of self-compassion
Need for self-care	Self-care as having physical separation from work
Need to be well to work with clients	Self-care as holistic care for the self
NHS support for staff wellbeing	Self-care as looking after the self
Not feeling valued at work	Self-care as multifaceted
Organisational culture/expectations in NHS	Self-care as self-indulgent
Others noticing one's own need for care	Self-care as self-nurture
Others' perspectives about self-care	Self-care brings equilibrium
Permission to self-care	Self-care easier than self-compassion
Personal therapy	Self-care entails lack of responsibility
Picking battles	Self-care has looked different at different times of life
Planned self-care	Self-care in and outside of work: distinct but related
Practical or physical activities	Self-care is dissimilar to work
Practical support from others	Self-care is not enough to cope with stressors
Pressure and targets in NHS	Self-care is not necessarily enjoyable
Prioritising self-care	Self-care leads to better client work
Proactive self-care	Self-care not explicitly considered before discussion
Reduced staff, same workload	Self-care to cope
Reactive self-care	Self-care to feel fulfilled as a person
Reading	Self-care to remain a whole person
Recharging effects of self-care	Self-care as sustaining
Reducing working hours	Self-care vs necessary behaviours
Resources vs demands	Self-compassion as a preferred concept to self-care
Responsibility for wellbeing	Self-compassion as self-care
Routine of self-care	Self-compassion necessary for self-care

Self-monitoring/checking in
Self-therapy
Sense of perspective
Sensual self-care
Sleep
Space for the self
Stress of admin
Supervision
Supportive others
Task-oriented Trust
Team relationships
Thresholds of stress
Time for reflection
Topics/activities unrelated to work
Trust not providing necessary support
Trust's priorities
Unconscious self-care
Unhealthy behaviours
Values
Work as self-care
Work as toxic
Work-life balance

APPENDIX O: EXAMPLE CODES WITH ASSOCIATED EXTRACTS

Code	Extract
Balancing own and others' needs	<p>Harry: And there's probably a tendency among our profession to be slightly skewed, and sometimes -</p> <p>Sarah: Skewed which way?</p> <p>Harry: To not look after ourselves</p>
	<p>Harry: And maybe I think the last one is a boundary, which is what Tanja just said there - is that to actually say 'no, I did promise on Saturday I'd come round for dinner, but I've reached the point where it's not going to help anyone, I need to cancel', I suppose, without feeling too guilty about it.</p>
	<p>April: I think it's absolutely about the rest of life, yeah. About how you manage that kind of boundary between what you want and need and what others want and need from you.</p>
	<p>Mia: I think that becomes quite tricky though, I mean, what you were saying Alice about kind of - and you were saying about protecting yourself, but at the same time, I go to toddler groups and things, and it's kind of being mindful about how many conversations I actually engage in about their child's problems! You know, err, not wanting to hear information about their work, hoping people don't start asking me questions about different things. But also thinking about ok, you know the meaning in life is really, is a really big thing for me. And part of that, I want my family and my friends to be well, and sometimes about facilitating that sometimes.</p>
	<p>Sue: But as we walked along this tow path we met somebody who told us his story, and then we met somebody else who told us his story. And then I said to this person I was with "I'm not going to engage in anymore stories, because this is about us having a walk with our dogs!" And I often get a lot of that. I call it bus stop - bus stop psychology, where if you let your defences down and you're friendly and kind, you can get sucked into many other things. So my toolkit has now got something in that is about 'it's alright to be polite and nice and lovely and friendly, but say no'.</p>

	<p>Alice: That's definitely in mine as well. Avoiding psychology talk outside of work, and in the family. I went on holiday with my mum recently, and, my dad died in January, and I, in my grief I thought "I'm going to take my mum to [place] for a few days. That will be great!" Never been on holiday with her on her own before, with good reason! And then something happened, oh, a couple of weeks before in her financial affairs, and so that was all that was on her mind. But I had to be really boundaried and just because, just that she's gonna, she uses me as her psychologist, and I just said "I'm not talking about that on holiday" (laughter). So I did have to shut her down a few times, and it felt quite horrible, but I just thought 'I can't do it. I just can't do it'. So that, not, and, you, and say the bus stop stuff, you just think "I don't want to have those types of conversations outside of work! Because I just haven't, just don't want to. Want it to be light and not thinking about stuff in depth all the time, and thinking about all the different ripples of, umm interpretation, and peoples points of view. Sometimes it is just what it is!"</p>
	<p>Mia: No but for example, like if I'm stressed or going through things I will prioritise my family, my closest friends, and maybe not really make a huge effort to make new friends, or you know, engage in conversation with people I don't know particularly well. Umm. Perhaps that limits you in some way, because perhaps you miss a lot, but you know, that's, I feel that's what I have to do.</p>
	<p>Sam: I guess for all of us that there are times when you can be too consumed by work, and maybe lose touch with other important things. And I think yeah, sometimes I can see how, because that, that sort of pull of demands from the children as they're more independent isn't quite as strong sometimes, so, it's important to monitor it.</p>
	<p>Eva: Sometimes, like in the past mostly, I will take on things, not necessarily about work, it could be like a friend calling saying 'oh can you please come by my house, something happened' or whatever, and then I would leave, umm, I wouldn't take care of myself if I was too tired or I had something else to do, I would just go and I would do something. Umm, but now I'm much more like, umm, true to myself. I have an awareness of what I can actually do and not do, and that's ok. In the past it wasn't that much ok, it was more, I had more guilt about that, about not doing things for other people or in the work place, but now I'm trying to be more, more protective of myself. So boundaries could be part of self-care. Errr, yeah.</p>
Exercise	<p>Harry: I do lots of tennis as exercise, as a counteract to sitting in front of the desk.</p>
	<p>Louise: I do a bit of exercise - I dance, a dance class.</p>

	Catherine: No, cus it doesn't have to be something that you particularly enjoy for it to be - I don't like exercise - I hate it. But I do it because it's good for me and I know it's good for me. So I don't think it has to be an emotionally, even a pleasurable activity, it's just something that you do - because you know it's good for you, because you know it kind of does do all those endorphins and help you switch off and does - it's something completely different.
	Catherine: Yeah. I would still say exercise is self-care, because it's good for you mentally, it's good for you physically, it does help you kind of relax afterwards and sometimes get a bit of a buzz. But the actual activity, I do not enjoy.
	April: I like to get completely away from psychotherapy when I'm not working. I do lots of exercise. Tennis and yoga, just completely get away from psychotherapy
	Yasmin: Yeah, and also, because it is such a heady job, isn't it as well. There is something about - and you talked about exercise as well, there's something about just physically getting back into your body somehow.
	Rob: I think exercise is really important as well as a way of looking after yourself, your diet and things. For me, with my last job I used to go to the gym as a part of my routine after work every day. And that was helpful, but I kind of, I just sort of got out of it here, but I cycle everywhere now, so that I guess that's my exercise cus I get to go to and from work and all around on my bike so a bit of exercise.
Ethos of department	Harry: And then you- realise actually how lucky in a sense we are, in spite of all the pressures, there's a lot worse out there than, than working here, so I'm always remembering that, and I suppose that narrative help me get through the day.
	Louise: Because of the physical health concerns that some members - previous members of the department have had, and there's been some traumatic illnesses and bereavements that people have had and I th - don't know if that's sort helped our sense of cohesion and helped that sort of care and support for each other, we sort of weathered storms together, and we have an experience of good leadership, and I suppose that helps you feel valued and I think when people feel valued maybe they're a bit more able to self-care?

Tanja: Yeah, and perhaps that's the - because of the approach of the management as well, they're fine, management here - approachable, and that they do care, which is, you know, in other workplaces, more stress comes from not being heard, or you know, they impose new ways of working, or do - do sudden tasks without you know, being listened to, and that causes a lot of stress as well. So it's umm - it's not just about the amount of work, or whatever, but it's also about - yeah, how you feel cared for or not, feeling supported.

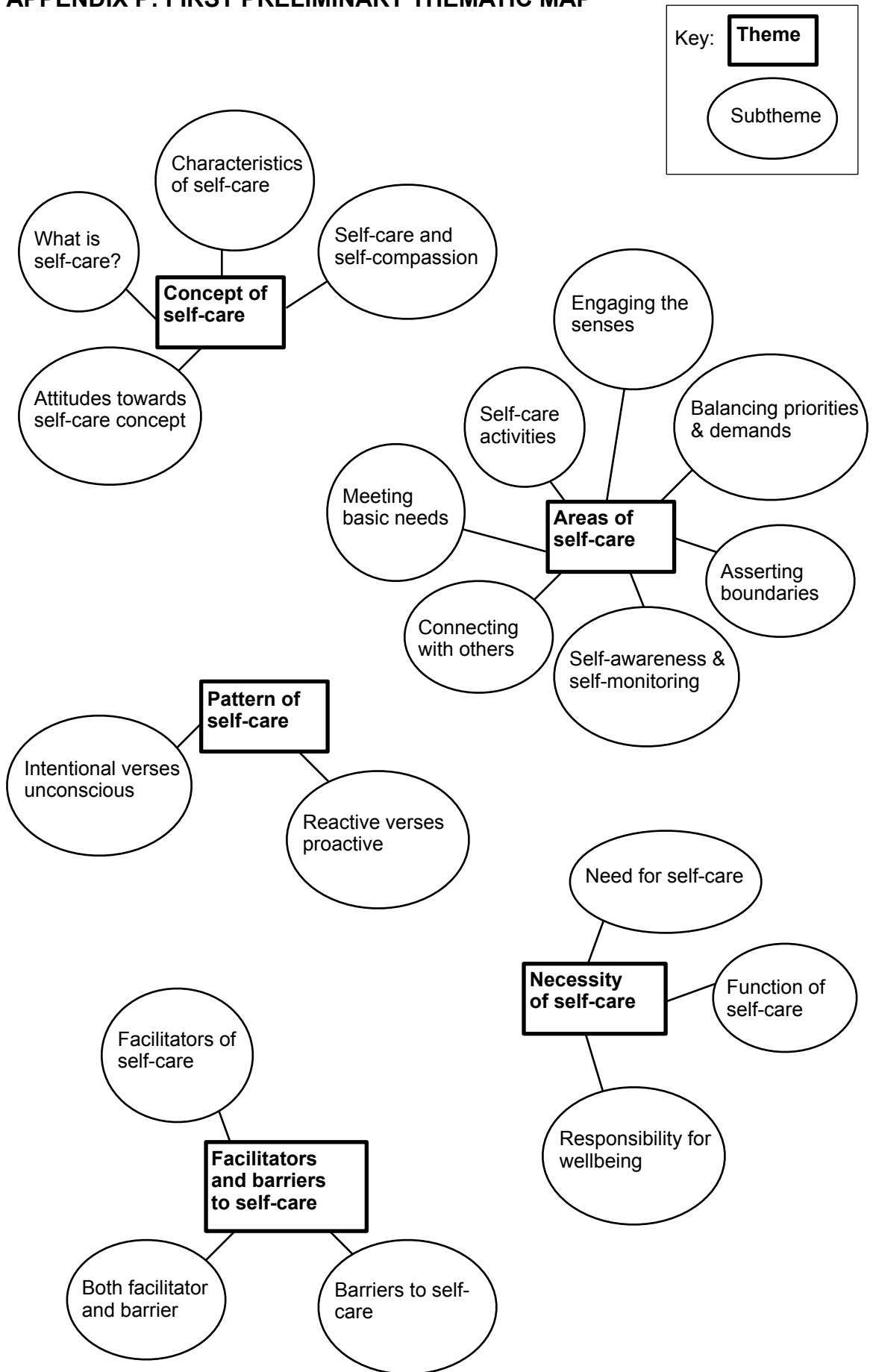
Emma: My mind had just gone to, yeah, very much the yeah, within - cus I work in two different teams, one is entirely psychology, and one is MDT. And the difference is massive. And the difference in my stress levels is massive in comparison in that it is much easier to self-care, to feel cared for in the psychology team than it is in the MDT. And the effect of my colleagues has a drip-drip effect on me as well. There are many more of those kind of 'must work harder' dynamics, and 'don't complain' and 'you're not here to have fun' - there are many many narratives that I hear a lot. That I think are the team's way of dealing with it, but I don't think it's a very self-caring way of dealing with it. And it's interesting that that affects me emotionally.

Sam: I suppose also it just made me think that we are, we sort of, some aspects of the system we create as well, and so how we, how we work with each other, how we relate with each other, how we behave in our teams for example, those sort of things are really important as well, and that umm, I suppose help, I suppose creating an atmosphere that is conducive to self-care.

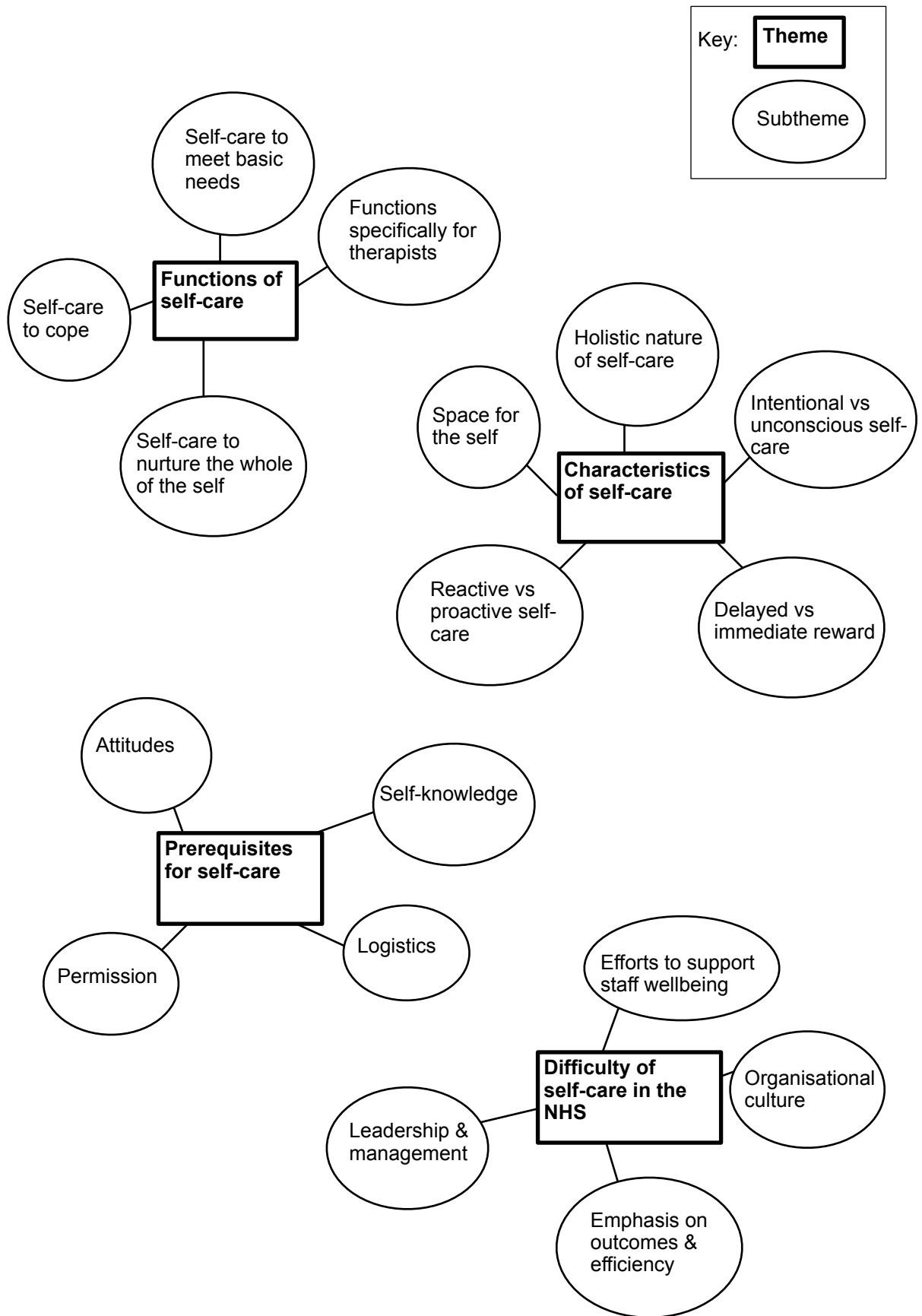
Zoe: it keeps coming back to me how difficult I found, in terms of grinding all this out, the first five or seven years post qualification, maybe let's say five anyway. Because I remember feeling like I had a lightbulb moment but not in a good way, when you know, feeling, you know, this is not a psychology department, this is a network of professionals. Cus I think I had an expectation of something maybe like what we have here, more team-ness, or shared something. And it just didn't exist!

Zoe: Something what missing in terms of leadership and creating, as you just said, some kind of atmosphere that's conducive to self-care, and even good practice actually, because they kind of go together. And I remember thinking "actually, I'm not going to find this in this place. I need to change my expectations".

APPENDIX P: FIRST PRELIMINARY THEMATIC MAP



APPENDIX Q: SECOND PRELIMINARY THEMATIC MAP



APPENDIX R: FINAL THEMATIC MAP

