Compassion, Burnout and Self-Care in NHS Staff Delivering Psychological Interventions

Lisa Jayne Walker

A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Professional Doctorate in Clinical Psychology

Submitted May 2017 (Revised August 2017)

Word Count: 23,015

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

Background

Staff burnout and lack of compassionate care in the NHS have been frequently highlighted in the press, in part due to the current emphasis in NHS policy on improving compassionate care and staff wellbeing. However, despite this media attention, the relationships between compassion, burnout and self-care remain under researched.

Aim

Specifically, this study aimed to investigate the associations between burnout, compassion for others, self-compassion and self-care. This study also aimed to explore the ways in which staff practise self-care.

Method

205 NHS staff who deliver psychological interventions completed an online survey. Associations between burnout, compassion for others, self-compassion and self-care satisfaction were measured quantitatively, through the use of three questionnaires: 1) the Maslach Burnout Inventory Human Services Survey, 2) the Compassion for Others Scale and 3) the Self-Compassion Scale, and a rating of satisfaction with their current level of self-care. Qualitative content analysis of open-ended responses was used to explore the ways in which the staff practised self-care.

Results

This study found a negative relationship between burnout and self-compassion, compassion for others and self-care satisfaction. Positive relationships between compassion for others, self-compassion and self-care satisfaction were also found. Participants cited a wide range of physical, psychological, social and professional self-care activities. Two-thirds of participants reported being satisfied with their self-care.

Conclusions

This study provides preliminary support for theories suggesting that self-compassion and self-care may reduce staff burnout and improve compassion for others. The compassionate mind approach was presented as a useful framework for formulating and addressing compassion, burnout and self-care in NHS staff.

Implications

Compassionate mind training (Gilbert, 2009) may be a suitable intervention and a form of staff self-care that could potentially reduce burnout and increase compassion for oneself and others.

ACKNOWLEDGEMENTS

1   INTRODUCTION

1.1   Overview

In this chapter, the current theoretical and empirical literature on the topics of compassion, burnout and self-care are critically reviewed and evaluated. The relevance of these topics for staff delivering psychological interventions in the National Health Service (NHS) is also highlighted. This study was written from a critical realist epistemological position, using the compassionate mind approach (Gilbert, 2005) as the overarching theoretical framework.

1.2   Literature Review Method

The literature was reviewed in accordance with the Centre for Reviews and Dissemination Guidelines (Akers, 2009). PsycINFO, CINAHL, Academic Search Complete, PubMed and Scopus databases were used for the literature search. Table 1 shows the combinations of search terms used.

Table 1. Search Terms Used in the Literature Review

NHS staff	Compassion	Burnout	Self-Care
clinician	caring	burnout	coping
counsellor	common humanity	compassion fatigue	coping strategies
healthcare staff /	compassion for self	depersonalisation	resilience
professional /	compassion	distress	self-care
personnel /	compassion for	emotional	stress management
practitioner /	others / humanity	exhaustion	
mental health staff /	compassionate	job burnout	
professional /	care	job satisfaction	
personnel /	empathy	occupational stress	
practitioner	kindness	personal	
NHS staff	mindfulness	accomplishment	
psychologist	self-compassion	quality of life	
therapist	self-kindness	secondary	
	self-love	traumatic stress	
	with suffering	(STS)	
		stress	
		vicarious trauma	
		well-functioning	
		wellness	
		work stress	
		impairment	
		wellbeing	

Only publications in English were selected. Both published journal articles and theses / grey literature were reviewed. The most relevant research to the current study is discussed in detail throughout this chapter and summarised at the end of this chapter. A variety of terms relating to staff delivering psychological interventions (e.g., 'therapist', 'mental health staff') and the people they work with (e.g., 'client', 'patient') were used in the literature review, in accordance with the source. In this chapter, research relating to compassion is discussed first, followed by research relating to burnout, self-care and self-compassion. The links between these topics are discussed throughout and summarised at the end of this chapter.

1.3 Defining Compassion

The majority of early work on compassion was conducted in a religious context, as compassion is viewed as a key aspect of many organised religions, such as Christianity, Islam and Buddhism (Welford, 2012). Across religions, compassion appears to convey a deep empathy for one's own or another's suffering, combined with a motivation to alleviate that suffering (Welford, 2012). In Buddhism, the Dalai Lama (2003) defines compassion as openness to the suffering of others, with commitment to relieve that suffering. In a secular context, the term 'compassion' has Latin roots, meaning 'with suffering'. This etymology suggests a two-fold meaning: compassion is a human response to suffering, but showing compassion without providing adequate support can also generate suffering (Firth-Cozens & Cornwall, 2009). Compassion can be experienced in multiple directions: compassion for others, compassion from others and self-compassion (Gilbert, 2005; Neff; 2003a). Here, compassion for others is discussed first, and self-compassion is discussed later in this chapter. Compassion from others is beyond the scope of this research, and is thus not discussed. However, it would be a useful direction for future research.

1.4 Compassion for Others

Combining Buddhist principles with theories of social psychology, Neff (2003b) suggests that compassion for others consists of three components:

- kindness: showing warmth and understanding towards others, as opposed to indifference or judgement;
- common humanity: recognising the shared experience of being human and understanding that suffering is part of the human experience, and thus enabling a sense of connection to, rather than separation from, others; and
- mindfulness: recognising the emotional states of others but allowing emotions to remain in balance by preventing avoidance or overidentification with the distress of others.

Pommier (2011) operationalised Neff's definition of compassion for others through the development of the Compassion for Others Scale, which is discussed in the Method chapter.

1.4.1 Limitations of the Construct of Compassion for Others

Neff's definition of self-compassion, which is discussed later in this chapter, is widely accepted in the scholarly community (MacBeth & Gumley, 2012). However, few studies have supported Neff's definition of compassion for others. Further, there is a lack of consensus in the literature regarding the conceptualisation of compassion for others: the terms 'compassion', 'sympathy' and 'empathy' are often used interchangeably or summarised under the umbrella term 'other-focused concern' (Neff & Pommier, 2013).

This study adopted the most widely accepted definitions of compassion, empathy and mindfulness. However, it is important to recognise that these constructs are culturally determined, so may vary in meaning across cultures. The discriminant validity of compassion, empathy and mindfulness has been the subject of much academic debate, and the terms have often been mistakenly used interchangeably within the Western literature (Mills & Chapman, 2016). Mindfulness is defined as awareness that arises through attention that is intentionally placed in the present moment, without judgement (Kabat-Zinn, 2003), and it is a key component of both Neff's (2003a) and Gilbert's (2005) definitions of compassion. The nature of the relationship between mindfulness and compassion is complex, as compassion has been suggested as both a quality and an outcome of mindfulness practice (Germer, 2009). However, Neff and Dahm (2014) argue that there are several distinctions between mindfulness and compassion. First, mindfulness is a method of relating to any experience, whilst compassion is specific to an experience of suffering or distress. Second, mindfulness is orientated towards experience, more generally, whereas compassion is directed towards oneself or others. Third, mindfulness involves acceptance of the present moment, whereas compassion involves the motivation to reduce suffering, and can thus be considered more active than mindful. Similarly, empathy is a component of compassion, yet it is distinct from

compassion, as empathy allows connection to another person's distress but does not involve the motivation to reduce that distress (Neff & Pommier, 2013).

Nonetheless, there is a growing interest in the science of compassion, spanning disciplines and integrating knowledge from religion, biology, neuroscience, developmental psychology, social psychology, evolutionary psychology and therapy outcome research (Gilbert, 2005). Gilbert (2005) suggests that compassionate behaviour evolved from an innate drive for attachment and affiliation. Reflecting on and extending Neff's (2003a) definition, Gilbert (2014) defines compassion as a sensitivity to suffering in oneself and others with a commitment to alleviating and preventing that suffering. He further describes compassion as consisting of two aspects: the ability to be motivated to engage with difficulties (as opposed to avoiding or supressing them) and the ability to focus on what is helpful.

1.5   The Compassionate Mind Approach

Gilbert's (2009) multimodal compassionate mind model proposes that compassion consists of six attributes: care for wellbeing, sensitivity, sympathy, distress tolerance, empathy and non-judgement. These attributes are thought to be developed through compassionate mind skills training involving: behaviour, reasoning, sensation, feeling, attention and imagery. The six attributes are distinct but interconnected, within a context of emotional warmth. The multimodal compassionate mind model is illustrated in Figure 1.
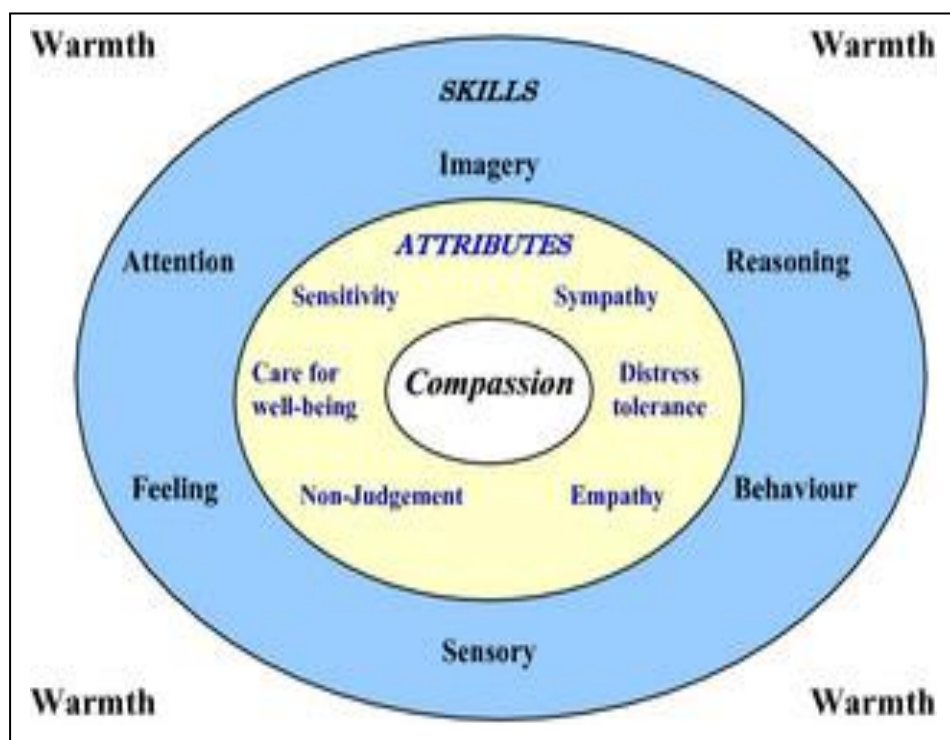
Figure 1. Multimodal compassionate mind training (Gilbert, 2009). The inner ring shows the attributes or qualities of compassion, whereas the outer ring shows the skills required to develop these attributes. Source: http://compassionatemind.co.uk/.

In more detail, Gilbert's six attributes of compassion are:

1. care for the wellbeing of oneself and others and a desire to reduce distress;
2. sensitivity to the feelings and needs of oneself and others;
3. sympathy to allow connection to the feelings of oneself and others;
4. distress tolerance, rather than distress avoidance;
5. empathy, to allow insight into and understanding of oneself and others; and
6. non-judgement and acceptance of oneself and others.

A key aspect of the compassionate mind approach is Gilbert's (2005) affect regulation systems model. Simplifying research in neuroscience, Gilbert's affect regulation systems model suggests the presence of at least three types of emotion regulation systems: a threat/protection system, a drive/excitement system and a soothing/contentment system. Each system is associated with

differential patterns of brain activity and neurochemistry. This affect regulation systems model is shown in Figure 2.
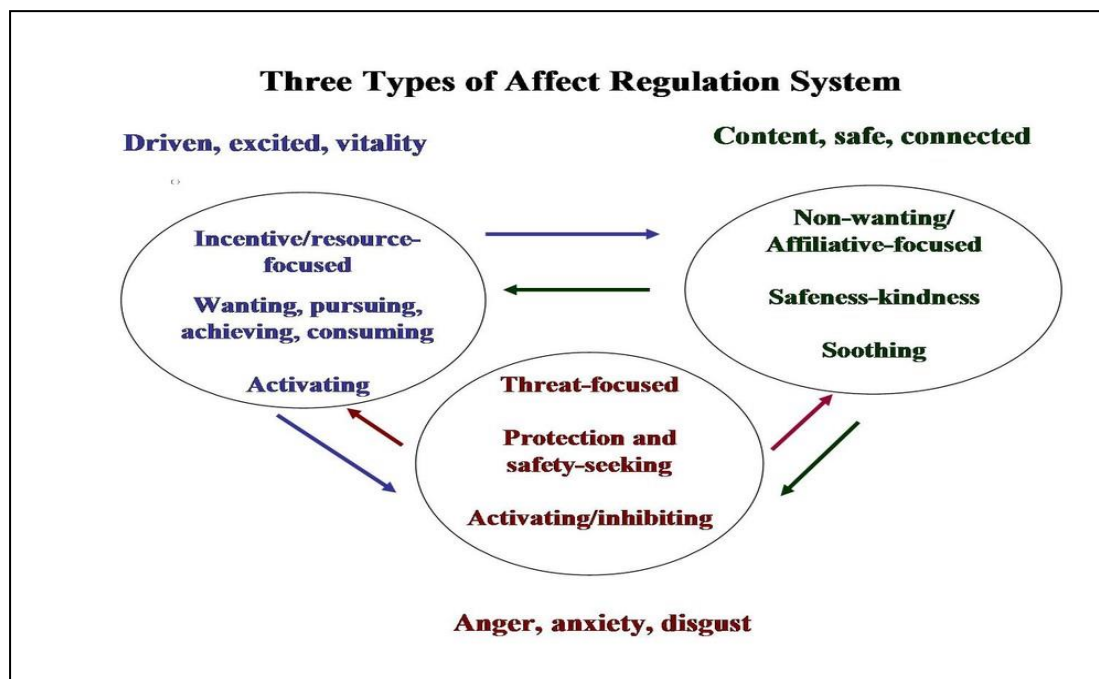
Figure 2. Gilbert's affect regulation systems model (2005). Source: http://compassionatemind.co.uk/.

1.5.1 Threat System

According to Gilbert, the threat system, which is associated with emotions of anxiety, anger and disgust, is triggered when an individual perceives a threat. From a neuroscience perspective, the threat system is associated with activation of the amygdala and the release of adrenaline and cortisol. Gilbert suggests that the threat system has been prioritised throughout evolution in order to facilitate self-protection and survival. For this reason, it can override the other systems. The threat system activates the fight/flight response, which inhibits any processes that are not essential for immediate survival, such as cognitive and emotional processing. Research in neuroscience suggests that when a person's threat system is activated, his or her ability to respond compassionately is limited (Russell, 2014).

1.5.2 Drive System

Gilbert suggests that the drive system motivates persons towards important goals, resources and achievements, through its association with emotions of excitement and pleasure. The drive system is thought to be related to activation of the nucleus accumbens and the release of dopamine. Gilbert proposes that if an individual's goals or values are blocked, the threat system is likely to be activated. Cole-King and Gilbert (2011) suggest that the consumerist nature of modern Western society, combined with the value placed on competition and achievement, has a tendency to overstimulate the drive system. This may become problematic if it throws the system out of balance with the threat and soothing systems, or if achievement becomes central to identity at the cost of other aspects of life, particularly social connectedness (Welford, 2012).

1.5.3 Soothing System

Gilbert proposes that the soothing system is associated with emotions of contentment, wellbeing, safety and compassion. The system is thought to be associated with activation of the prefrontal cortex and the release of opiates and oxytocin. Activation of the soothing system is associated with attachment and affiliation, and it allows individuals to be present, socially connected and compassionate towards themselves and others. Neff (2003a) proposes that the soothing system can be activated by compassion from both the self and others.

1.5.4 Development and Interaction of the Affect Regulation Systems

Gilbert proposes that distress is caused by an imbalance of the three systems – particularly an imbalance caused by an underdeveloped soothing system and an overdeveloped threat system. Research in neuroscience suggests that, during early life, brain connections that are frequently used are strengthened (Gerhardt, 2014). It follows that whichever system is activated most frequently in early life is likely to become dominant in later life. Thus, the development of these systems is determined by experience, and particularly attachment. In order to develop a soothing system, for instance, one must internalise the experience of being soothed (Gilbert, 2005). However, if an individual's early environment is dangerous, he or she may overdevelop the threat system in order to adapt

(Gilbert, 2005). An overactive threat system can result in an overestimation of threat, attention bias towards negative stimuli (and simultaneous discounting of positive stimuli), rumination and worry, and these processes can subsequently reinforce activation of the threat system.

Gilbert (2005) suggests that activation of the soothing system reduces activation of the threat and drive systems. This model can potentially be used to understand the factors that influence compassion. For example, the ability to be compassionate towards oneself and others may be reduced by an underdeveloped soothing system or an overdeveloped threat or drive system. Furthermore, Gilbert (2009) suggests that – through compassionate mind training – the soothing system can be strengthened to help bring the systems into balance and subsequently reduce distress and increase compassion.

1.5.5 Limitations of the Compassionate Mind Approach

The main critique of the compassionate mind approach relates to its oversimplification. However, Gilbert (2005) argues that the simplification serves to increase the model's accessibility.

Although acknowledging that the external environment, with both caregivers and the wider environment (e.g. social exclusion), determines the development of the affect regulation systems, the compassionate mind approach remains more individual-focused regarding the processes of maintenance and change. For example, compassionate mind skills training focuses at the individual level, such as engaging in compassionate imagery. This assumes individuals have the ability and power to change, when critical psychologists would argue that the ability to change is constrained and enabled by social context and power (Fox, Prilleltensky, & Austin, 2009).

Another limitation of the approach is its unclear cross-cultural relevance. For example, collectivist cultures emphasise interconnectedness to others, which is associated with the soothing system; individualistic cultures (such as the UK), in contrast, tend to value achievement and competition, which are associated with

the drive system. The current study was set entirely within the context in which the compassionate mind approach was developed (the UK). However, the UK is not a homogenous population. Although ethnicity data was gathered, data regarding nationality or religion of participants was not collected due to limitations imposed by survey length and response rate. Subsequently, whether or not participants identified more with collectivist or individualistic culture was unknown. Furthermore, the diversity of NHS staff delivering psychological interventions is increasing. There is a continued drive to increase BME access to clinical psychology training programmes (Turpin & Coleman, 2010) and many Improving Access to Psychological Therapy (IAPT) services actively recruit staff to represent the diversity of the local population.

Another confusion regarding the terminology applied in the literature is the interchangeable use of 'compassion-focused therapy' (CFT) and 'compassionate mind training' (CMT). CFT originates from the cognitive-behavioural therapy (CBT) approach (Gilbert, 2010), wherein each affect regulation system is associated with a different pattern of thoughts, feelings, physical symptoms and behaviours. Beaumont and Hollins Martin (2016) suggest that CFT describes the process and theory of Gilbert's model, whereas CMT refers to specific interventions aimed at activating the soothing system through training in compassionate skills. However, in the literature, the terms 'compassionate mind training' and 'compassion-focused therapy' appear to be used interchangeably. To reduce confusion, this study adopted the term 'compassionate mind approach' when referring to Gilbert's theories and models of compassion.

1.6   Compassion in the NHS

This study focused on the NHS and the staff delivering psychological therapies within it, due to the different ways healthcare is funded in different countries and differences in staff training routes, and the context in which this study was conducted. In Australia, Canada and New Zealand general taxation is the main source of funding for health care. In the U.S. and Switzerland, private health insurance is the dominant form of healthcare cover, compared to the U.K. where

only 10% of the population have private healthcare cover. Although NHS services are increasingly focused on patient choice and satisfaction, patients may have differing expectations for care depending on personal cost. The cost and length of training as a healthcare provider also varies across countries, perhaps with an impact on healthcare delivery and compassionate care. However, these topics are beyond the scope of the current study.

Spandler and Stickley (2011) state that compassion should underpin all healthcare policy and practice. In line with this, compassion is one of the core values of the NHS, and is understood to involve an understanding of the suffering of others and a desire to relieve this suffering (Department of Health, 2015). Relating specifically to NHS staff delivering psychological interventions, Gilbert and Leahy (2007) argue that the capacity to be compassionate towards others should be a requirement for clinical work, and particularly psychotherapeutic work.

Since the Mid-Staffordshire Inquiry (Francis, 2013), which identified lack of staff compassion as a factor resulting in poor patient care and patient abuse, there has been a drive to improve compassionate care in the NHS (Mills, Wand, & Fraser, 2015). This drive has resulted in a number of policy directives and staff training schemes, such as values-based recruitment and a 'Compassion in Practice' e-learning programme. The 'Compassion in Practice' programme was published by the Department of Health in 2012 as a guideline for all healthcare staff, establishing care, compassion, competence, communication, courage and commitment as the '6 Cs' of compassionate care. Despite this emphasis on compassionate care in NHS policy, there is a lack of research operationalising and exploring compassionate care.

1.7   Measuring Compassionate Care

In a review of studies in which compassion in healthcare had been measured, Papadopoulos and Ali (2015) found that no standardised measures of compassionate care had been used. Instead, general measures of patient

experience or satisfaction (e.g., the NHS Friends and Family Test) had been assumed to indirectly measure compassionate care. Compassion in Practice (Department of Health, 2012) states that dissatisfied patients often cite a lack of compassion, suggesting that if patient satisfaction is viewed as an outcome then compassionate care clearly matters. Spandler and Stickley (2011) state that the qualities associated with compassionate care are not easily measurable, so attempts at quantification are problematic. However, given the current prioritisation of evidence-based practice and outcome monitoring in the NHS, this inability to quantify compassion proves difficult. Spandler and Stickley and Maben (2014) suggest that the NHS has become an 'audit culture', privileging second-order measurable activities over first-order activities (e.g., therapeutic relationships), which are more difficult to measure. Both Figley (2002) and Gilbert and Leahy (2007) suggest that the expression of compassion by therapists is associated with the strength of the therapeutic relationship. This is important as reviews of psychotherapy outcomes suggest that the therapeutic relationship correlates more strongly with client outcomes than do specific treatment interventions (Carr, 2013; Roth & Fonagy, 2006). Drawing this evidence together, it may be the case that compassionate care from therapists is associated with better client outcomes via the therapeutic relationship. The failure to operationalise compassionate care may partially explain why compassion in practice remains under researched, with a larger body of research dedicated to empathy and compassion fatigue, as opposed to compassion, itself, or compassionate care (Fernando & Consedine, 2014).

1.8   A Model of Compassionate Care

Firth-Cozens and Cornwell (2009) state that while the majority of research is focused on the individual level, factors influencing compassionate care operate at multiple levels in the NHS, relating to: individual clinicians, professional roles and training, teams and services, and the wider NHS. Reflecting the variety of factors influencing clinician compassion, Fernando and Consedine (2014) propose a transactional model of physician compassion, as shown in Figure 3. The model suggests that compassion is influenced by the complex interaction of clinician,

clinical, patient, family, environmental and institutional factors. Although the model focuses on physicians, it could potentially be applied to NHS staff delivering psychological interventions. It could also be integrated with Gilbert's compassionate mind approach to identify both individual and systemic levels at which the threat system may be activated and compassion subsequently reduced.
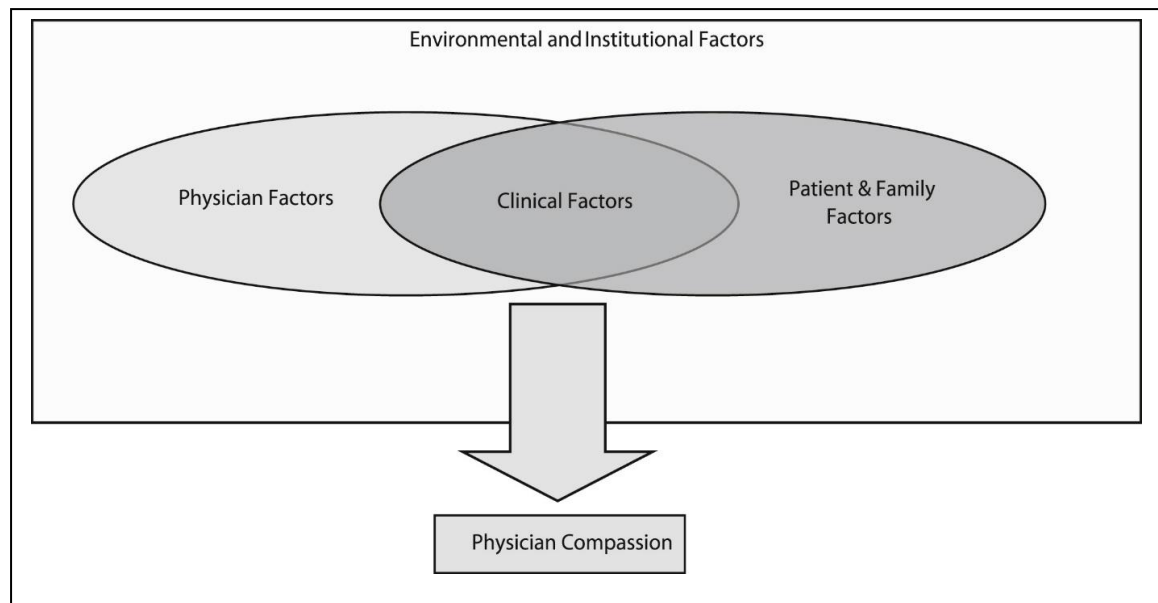
Figure 3. The transactional model of physician compassion (Fernando & Consedine, 2014).

1.8.1 Clinical Factors Influencing Compassionate Care

Fernando and Consedine suggest that the clinician factors that influence compassion include: personal history (e.g., early trauma leading to an overactive threat system), appraisal of the situation, personality and resources.

In line with CBT theory, which holds that a person's appraisal determines his or her response to a situation (Beck, 1979), Mills and Chapman (2016) suggest that compassion for oneself or others is influenced by an appraisal of whether compassion is deserved. Accordingly, Teater and Ludgate (2014) suggest that certain clinical presentations in which a patient is deemed (unconsciously or consciously) 'responsible' (e.g., substance misuse or obesity) are less likely to result in a compassionate response. Further, compassion is likely reduced when

25

a patient or family member triggers the clinician's threat system – for example by displaying challenging or aggressive behaviour or complex chronic presentations that generate clinical uncertainty and anxiety.

1.8.2 Environmental and Institutional Factors Influencing Compassionate Care

Cole-King and Gilbert (2011) claim that compassionate care can only occur through compassionate individuals (staff) within compassionate organisations (the NHS). A compassionate environment is one in which staff feel safe and are provided with support and compassion from their colleagues and the system. In terms of the compassionate mind approach, a compassionate environment enables activation of the soothing system. In contrast, environments and institutional factors associated with reduced compassion are likely to trigger the threat system. Cole-King and Gilbert (2011) suggest that several contextual issues within the NHS may activate the threat system in staff, including a lack of resources (e.g., inadequate staffing and supervision) and occupational targets. Job uncertainty and increased competition for jobs and services (created by tendering and funding cuts) are likely to lead to increased activation of both the threat and drive systems (Cole-King & Gilbert, 2011). Egan, Mantzios and Jackson (2016) suggest that increasing demand for consistent compassionate care is extremely important, but that focusing on the individual clinician level and mandating compassionate practice in staff may result in staff burnout and reduce staff self-care. The following section focuses on burnout, relating its causes and consequences to the compassionate mind approach and describing the impact of staff burnout on compassionate care. Self-care is discussed later in this chapter.

1.9 Defining Burnout

The Oxford Dictionaries Online (2016) defines 'burnout' as physical or mental collapse caused by overwork or stress. Maslach (1982) suggests that burnout is specific to individuals who work with people, particularly in a helping role, and is thus distinct from occupational stress. Burnout is conceptualised by Maslach, Jackson and Leiter (1996) as a syndrome involving three aspects (in varying

degrees, ranging from low to high): emotional exhaustion, depersonalisation and reduced personal accomplishment.

1.9.1 Emotional Exhaustion

Maslach et al. (1996) define emotional exhaustion as feelings of being emotionally overextended and exhausted by one's work. Burnout, more generally, may be a consequence of chronic overactivation of the threat system (Gilbert & Choden, 2015). Figley (2002) suggests that long-term work with people in mental distress can deplete staff's emotional resources and generate psychological distress. Figley suggests that therapists with higher levels of compassion are at greater risk of emotional exhaustion and burnout, due to overidentification with client distress.

1.9.2 Depersonalisation

Maslach et al. (1986) define depersonalisation as an unfeeling and impersonal response towards recipients of one's service, care or treatment. It may also be a response to activation of the threat system, aimed at escaping a perceived threat or avoiding further distress (Firth-Cozens & Cornwell, 2009). Firth-Cozens and Cornwell (2009) suggest that depersonalisation is the aspect of burnout that is most likely to impair compassion towards clients, as it involves emotional distancing and reduction of one's empathy towards clients.

1.9.3 Reduced Personal Accomplishment

Maslach et al. (1996) define reduced personal accomplishment as feelings of incompetence and lack of successful achievement in one's work with people. Reduced personal accomplishment is associated with feelings of self-doubt and negative self-evaluation, and it is particularly likely to occur in therapists whose self-esteem is contingent on their work performance (Teater & Ludgate, 2014). Vivino, Thompson, Hill and Ladany (2009) suggest that feelings of incompetence are likely to hinder compassion in therapy.

1.10 Measuring Burnout

Maslach et al. (1996) operationalised their conceptualisation of burnout through the Maslach Burnout Inventory (MBI), which has become the most widely used measure of and framework for defining burnout (Lee et al., 2011). The MBI has been translated and tested in various countries including: U.S., Canada, U.K., Germany, New Zealand, Japan and Russia. A similar factor structure was found across countries (Poghosyan, Aiken, & Sloane, 2009), although homogeneity within each country must not be assumed. While Maslach, Schaufeli and Leitner (2001) acknowledge that the discriminant validity of 'burnout' has been widely debated (particularly in the context of its overlap with symptoms of depression, anxiety and stress), they argue that burnout is specifically related to the work context, whereas depression is a clinical syndrome that affects global functioning. Maslach et al. (2001) also state that burnout is associated with – but distinct from – stress and job dissatisfaction.

Stamm (2010) suggests that burnout is an element of 'compassion fatigue' when it occurs in combination with 'secondary traumatic stress' (also known as 'vicarious trauma'). Figley (2013) defines vicarious traumatisation as involving PTSD-like symptoms, as experienced by professionals working with traumatised patients. Although a standardised measure of compassion fatigue exists – the Professional Quality of Life (ProQOL; Stamm, 2010) measure – this measure is specific to those who work with victims of trauma. Therefore, burnout was chosen as the preferred variable to investigate in this study, as it applies to the wide range of staff delivering psychological interventions and the various NHS services in which they work.

1.11 A Model of Burnout

Teater and Ludgate (2014) conceptualised the symptoms of burnout using a CBT model (Greenberger, Padesky, & Beck, 2015), as shown in Figure 4. Several of these symptoms overlap with symptoms associated with activation of the threat system in Gilbert's compassionate mind approach, such as: muscular

pain/tension, sleep problems, poor concentration, hypervigilance and anxiety. Other symptoms relate to activation of the drive system, such as: overworking, a lack of work/life balance and an increased sense of responsibility.

Cognitive
Negative/unhelpful beliefs/thoughts about: oneself (e.g., feeling that one is incompetent or overly responsible), clients (e.g., viewing them as difficult or blaming) or work (e.g., feeling that work is hopeless, uncontrollable, unfair or overwhelming)
Reduced concentration, attention and decision-making and flexibility; increased rumination and hypervigilance

Physical
Low motivation and energy
Sleep problems
Muscle pain/tension
Physical health problems (e.g., headaches, back pain, IBS, increased blood pressure)
Reduced immunity

Emotional
Loss of humour
Irritability/frustration
Depression
Anxiety
Apathy
Guilt
Anhedonia

Behaviours
Work avoidance (e.g., absenteeism, lateness, procrastination)
Social isolation (including from colleagues)
Lack of work/life balance
Unhelpful coping strategies (e.g., substance abuse, overeating)
Overworking
Interpersonal/relationship problems

Figure 4. Teater and Ludgate's (2014) cognitive-behavioural conceptualisation of burnout.

1.12 Factors Influencing Burnout

Similar to the range of factors that influence compassion at different levels, a combination of individual, occupational and organisational factors determine the experience of burnout (Maslach et al., 1996). When demands are appraised as exceeding resources, a person experiences stress (Lazarus & Folkman, 1984).

Maslach et al. (1996) suggest that burnout is specific to individuals who work with people, particularly in a helping role. However, 'working with' should not assume a paid job role as there is evidence of burnout in volunteers (Kulik, 2006) and family carers (Angermeyer, Bull, Bernert, Dietrich, & Kopf, 2006). Whilst there is a large body of evidence highlighting high levels of burnout in human service workers in non-healthcare professions including: social workers, teachers, police and firefighters (Maslach, Schaufeli, & Leiter, 2001), there is also evidence that a number of other professions are affected by burnout, including corporate lawyers (Berger, 2000) and professional athletes (Cresswell & Eklund, 2006). High levels of burnout have also been evidenced in students, with a specific variation of the MBI – the MBI Student Survey (MBI-SS) – developed to measure burnout in this population (Schaufeli, Martinez, Pinto, Salanova, & Bakker, 2002).

Rupert, Miller and Dorociak (2015) hypothesise that mental health staff are especially vulnerable to burnout because their work involves a unique combination of occupational (client-related) and organisational (service-related) stressors. Clinical presentations that are associated with increased risk of burnout are suicidality, hostility, personality issues and trauma (Teater & Ludgate, 2014). Organisational stressors include an excessive workload (including paperwork), service constraints, a lack of autonomy, role ambiguity and conflict with colleagues – particularly supervisors (Rupert et al., 2015). The occupational and organisational factors that are cited as sources of stress and burnout in a recent survey of NHS psychological therapies staff included: an excessive focus on targets, an increased volume and complexity of cases, extra administrative demands, unpaid hours and resource cuts (Rao et al., 2016). Cole-King and Gilbert (2011) suggest that staff are more likely to experience burnout when they feel that their work culture constrains them from acting compassionately. Beaumont and Hollins Martin (2016) suggest that burnout can be a response to distressing clinical interactions, which can subsequently prevent compassion for both oneself and others.

From a compassionate mind approach, Russell (2014) proposes that when staff are repeatedly exposed to high levels of distress without receiving adequate

training on regulating their emotions (or when they lack the ability to activate their soothing system), their emotions can become repressed and this can manifest in burnout.

As discussed, an overdeveloped threat system and an underdeveloped soothing system are often – but not always – a consequence of difficult early life experiences (Welford, 2012). Difficulties in early life are risk factors for mental health problems (Rutter, 1985) and burnout (Maslach et al., 2001). Childhood difficulties, especially in the area of attachment, are more common in healthcare professionals than in the general population (Ballatt & Campling, 2011). Tillett (2003) suggests that healthcare staff who have experienced more severe childhood disruption are more likely to experience burnout.

1.13 Prevalence of Burnout

The Institute for Quality and Efficiency in Healthcare (2016) state that the lack of diagnostic criteria for burnout makes estimations of prevalence problematic. However, from a review of the literature on burnout in mental health services, Morse et al. (2012) estimated that 21 to 67% of mental health workers experience high levels of burnout. Hill et al. (2006) found that UK mental health staff have the highest rates of burnout in Europe. Using the MBI-Human Services Survey (Maslach & Jackson, 1981), Prosser et al. (1996), Onyett et al. (2009) and Johnson et al. (2012) found high levels of emotional exhaustion yet low levels of depersonalisation and high levels of personal accomplishment in UK mental health staff. However, the majority of the sample were nursing or medical staff, and only a small proportion of each subsample consisted of staff delivering psychological interventions.

Rao et al. (2016) conducted an online wellbeing survey involving 1,106 staff working in psychological therapy services across the UK, including: 'Improving Access to Psychological Therapies' (IAPT), secondary and tertiary services. The survey consisted of closed questions from the Work-Related Quality of Life Scale (Van Laar, Edwards, & Easton, 2007) and comments via free text. Almost half of

the sample (49.5%) reported feelings of failure. They also reported lower levels of job satisfaction than NHS staff groups who were not working in psychological therapy services.

1.14 Consequences of Burnout

1.14.1 The Impact of Burnout on Compassionate Care

Negash and Sahin (2011) propose that therapists who are emotionally exhausted may be less able to empathise with clients and to depersonalise their presenting problems, leading to inappropriate interventions and reduced service quality. In support of this claim, burnout in mental health staff has been associated with reduced fidelity to evidence-based practice (Mancini et al., 2009). Garman, Corrigan and Morris (2002) found an association between mental health staff burnout and patient satisfaction, with emotional exhaustion found to have the greatest impact. Systematic reviews of patient safety in UK healthcare institutions have found that staff burnout is significantly associated with patient neglect and safety (Hall, Johnson, Watt, Tsipa, & O'Connor, 2016; Reader & Gillespie, 2013). However, in a review of the literature on burnout in mental health staff, Morse et al. (2012) found a lack of research investigating the impact of mental health staff burnout on client care and outcomes. Olson, Kemper and Mahan (2015) conducted a study using the Jefferson Scale of Physician Empathy (Hojat et al., 2001), finding no significant relationship between empathy and burnout. However, as previously discussed, empathy is a component of – and not equivalent to – compassion. Several limitations and methodological issues in research on burnout in mental health staff has been highlighted, such as the interchangeable use of 'stress', 'distress' and 'burnout' terminology (Smith & Moss, 2009) and the lack of validated measures (Hannigan, Edwards, & Burnard, 2004; Papadopoulos & Ali, 2015). Further, the majority of research has been conducted in the US, and the corresponding differences in training and healthcare systems potentially limit the generalisability of these studies to a UK context (Edwards, Hannigan, Fothergill, & Burnard, 2002). Although compassion for others cannot be assumed to be equivalent to compassionate care, only three UK empirical studies to date have been conducted investigating the relationship

between burnout and compassion of others. Beaumont et al. (2016b) found a negative relationship between burnout (as measured by the PRO-QOL) and compassion for others (as measured by the (Compassion for Others Scale) in counselling and CBT trainees. However, this relationship was not significant using the same measures in student midwives (Beaumont et al., 2016a) and community nurses (Durkin et al., 2016).

1.14.2 The Impact of Burnout on Staff

Consequences of burnout for individual staff can include physical and mental health problems such as depression, suicidality, sleep disturbance, poor concentration, substance misuse and interpersonal problems (Emery, Wade, & McLean, 2009; Morse, 2012). These difficulties are likely to affect staff's personal and professional functioning (Morse, 2012). However, these consequences of burnout have been identified by cross-sectional studies, and it is thus difficult to conclude whether they are true consequences of burnout or merely non-causal correlates, or even antecedents. Despite theoretical efforts to distinguish burnout from depression, anxiety and stress, studies have shown that the symptoms of these conditions do overlap. Rao et al. (2016) found that 46% of NHS psychological therapies staff reported depression and 25% considered themselves to have a chronic mental health condition. A further 70% reported that they found their job stressful and 37% reported feeling unwell due to work-related stress and pressure. These findings support suggestions of a higher prevalence of mental health problems in NHS staff relative to the general population (Tillett, 2003). For example, using the General Health Questionnaire (GHQ-28; Goldberg & Hillier, 1979), Cushway and Tyler (1996) found that 40% of UK clinical psychologists met the 'caseness' criterion, indicating 'just significant clinical disturbance', compared with 28% of a working adult sample. Meltzer et al. (2008) found that healthcare professionals had the highest rates of suicide in England and Wales, compared with those in other occupational groups.

1.14.3 Preventing Burnout through Self-Care

Egan et al. (2016) suggest that the focus on compassionate care and outcomes in the NHS may lead staff to prioritise work at the expense of their own needs,

and this could potentially result in burnout and a lack of self-care. This was previously suggested by Freudenberger (1974), who proposed that burnout in helping professionals results from their high ideals and over commitment to their occupation – particularly in those who care for others at the expense of their own needs. Barnett et al. (2007) state that the practice of psychology can be demanding, challenging and emotionally taxing, and that neglect of one's own wellbeing and failure to practise self-care can place a psychologist at risk of burnout and impaired professional functioning. Similarly, Figley (2002) suggests that compassion fatigue is due to a chronic lack of self-care in psychotherapists. Several authors claim that self-care is the most important factor in preventing – or reducing – therapist burnout (Barnett et al., 2007; Good, Khairallah and Mintz, 2009; Malinowski, 2014; Smith and Moss, 2009). Teater and Ludgate (2014) suggest that preventative factors against therapist burnout include strong personal and professional/peer social support systems, work/life balance, supervision and self-awareness. Good et al. suggest that burnout and self-care are interrelated, as burnout results in impaired functioning, causing a psychologist to take longer to complete tasks. This results in the psychologist working longer hours, which reduces their time and energy available for self-care. However, there is a lack of empirical evidence supporting these claims, perhaps due to the lack of conceptualisation and operationalisation of self-care (Richards, Campenni & Muse-Burke, 2010).

1.15 Defining Self-Care

Mills and Chapman (2016) suggest that self-care in healthcare staff involves various strategies of promoting or maintaining physical, psychological and spiritual health, as well ensuring that personal and family needs are met. The authors suggest that self-care requires self-reflection and sufficient awareness to identify both personal and professional stressors and supports. Similarly, Barnett and Cooper (2009) propose that the goal of self-care is to maintain professional functioning and wellbeing over time, despite personal and professional stressors. Additionally, Wise, Hersh and Gibson (2012) argue that self-care is an ethical imperative, as it is required for the effective treatment of clients.

The terms 'self-care', 'coping strategies', 'career-sustaining behaviours' and 'burnout prevention' are used interchangeably in the literature (Brownlee, 2016). However, Brucato and Neimeyer (2009) suggest that the difference between self-care and coping strategies is that self-care involves proactive strategies aimed at preventing stress, whereas coping strategies are reactive strategies aimed at reducing stress. Following a thematic analysis of interviews with seven UK counsellors, Brownlee (2016) suggested that self-care is a process of recognising one's physical, emotional and spiritual needs and finding personal and flexible ways of meeting those needs. Another emerging theme was the perception that self-care is important but associated with feelings of guilt, selfishness and self-indulgence, so for this reason, it is difficult to prioritise. However, due to the small sample size of the study, the generalisability of its findings is unclear.

1.16 Measuring Self-Care

There are currently no standardised measures of clinician self-care. The two most frequently cited assessments, the Self-Care Assessment Worksheet (SCAW; Saakvitne and Pearlman, 1996) and the Skovholt Practitioner Professional Resiliency and Self-Care Inventory (Skovholt & Trotter-Mathinson, 2011), have not been validated, as they were originally intended as informal self-reflective worksheets (Pearlman, personal communication). The SCAW lists a number of self-care activities under the dimensions of physical, psychological, emotional, spiritual and workplace/professional self-care and balance. Using a Likert scale, therapists rate the frequency with which they engage in each activity. However, a criticism of this measure is that activity frequency cannot be assumed to be indicative of usefulness or effectiveness. The Skovholt Inventory consists of a checklist of statements relating to four subscales: Professional Vitality, Personal Vitality, Professional Stress and Personal Stress. Therapists rate their agreement with the statements using a Likert scale. However, this measure was seemed unsuitable for use in this study on the basis that vitality subscales cannot be assumed to measure self-care, nor can stress subscales be assumed to measure burnout.

1.17 Models of Self-Care

There are several self-care workbooks for therapists, including: *The Therapist's Workbook* (Kottler, 2011), *Leaving it at the Office* (Norcross & Guy, 2007), *The Resilient Practitioner* (Skovholt & Trotter-Mathison, 2011), *Overcoming Compassion Fatigue* (Teater & Ludgate, 2014), *Transforming the Pain* (Saakvitne & Pearlman, 1996) and *The Compassion Fatigue Workbook* (Mathieu, 2011). These books follow a similar format of identifying stressors and self-care strategies. However, some are specific to compassion fatigue and vicarious trauma, rather than burnout, more generally. Further, all of the books listed above were developed in the US and predominantly written for psychotherapists, so their relevance for NHS staff delivering psychological interventions cannot be assumed.

Very few published empirical studies have focused on therapist self-care, perhaps due to the lack of standardised measures. Norcross and Guy (2007) proposed a 12-principle model of self-care based on factors contributing to professional psychologists' healthy functioning (Coster & Schwebel, 1997) and career-sustaining behaviours (Stevanovic & Rupert, 2004):

1. prioritising self-awareness and self-care;
2. refocusing on career satisfaction;
3. recognising occupational hazards;
4. healthy eating, adequate sleep and exercise;
5. nurturing relationships;
6. boundary setting: mentally, physically and electronically;
7. restructuring cognitions, particularly perfectionism;
8. holidays and activities unrelated to the profession;
9. evaluating work in relation to: workload, control, rewards, sense of community, respect and values;
10. personal therapy and self-development;
11. spirituality and values; and

12. continuing professional development activities (CPD) and diversification of work.

However, there is currently no evidence of whether (or how) this model is actually applied in practice. Furthermore, the career-sustaining behaviours and factors contributing to healthy functioning, on which the model is based, cannot be assumed to be equivalent to self-care or factors preventing burnout.

In a review of self-care in US mental health staff, Malinowski (2014) summarised self-care activities along psychological, spiritual, physical and social (personal and professional) dimensions, as illustrated in Table 2. However, this summary was based only on US literature, so its relevance to NHS staff cannot be assumed.

Table 2. Summary of Self-Care Dimensions and Activities

Self-Care dimension	Example activities, practices, etc.
Psychological	Self-awareness
	Mindfulness
	Personal therapy
	Positivity
	Humour
Spiritual	Spirituality
	Religion
	Meditation
Physical	Exercise
	Leisure
Social (personal and professional)	Friends and family
	Peer support
	Supervision

Malinowski (2014).

The only study of therapist self-care in the UK, conducted by Brownlee in 2016, drew on interviews with seven counsellors. Brownlee (2016) categorised self-care activities into personal (physical and psychological) and professional self-care, following thematic analysis of interview transcripts, as shown in Table 3.

However, due to the small sample of this study, the validity of its wider generalisability to NHS staff delivering psychological interventions is unknown.

Table 3.Counsellor Self-Care Activities

Personal self-care activities (outside the counselling environment)		Professional self-care activities (directly linked to client work)
Physical	**Psychological**	
Healthy diet	Seeing friends and family	Supervision
Exercise	Spending time alone	Group supervision
Time spent outdoors	Reading and writing	Peer support
	Exercising mindfulness	Tutorials
	Engaging with music	Conferences and workshops
		Personal therapy
		Personal development groups
		Check ins
		Skills group
		Journal writing

Brownlee (2016).

1.18 Benefits of Self-Care

As discussed above, several authors theoretically propose that self-care is the most important factor in preventing therapist burnout (e.g., Smith & Moss, 2009). Mills and Chapman (2016) argue that caring for others whilst neglecting oneself is neither safe nor sustainable practise. Furthermore, self-care enables staff to care for their patients with greater compassion and effectiveness, whereas advice about self-care may be ignored or seen as hypocritical when a clinician does not model self-care (Mills & Chapman, 2016).

Empirical studies have found that engaging in activities cited as forms of self-care have been associated with lower levels of burnout. For example, Ringenbach (2009) found lower levels of burnout in therapists who meditated and Linley and Joseph (2007) found lower levels of burnout in UK therapists who engaged in

personal therapy. Further, Walsh and Cormack (1994) cited engagement with peer support groups as a form of self-care that normalised distress in UK psychologists.

In the USA, a negative relationship between self-care strategies and burnout was found in hospice care professionals (Alkema, Linton, & Davies, 2008) and mental health therapists (Catlin-Rakoski, 2012). However, because the studies used small sample sizes and drew on the Self-Care Assessment Worksheet (SCAW) (which is not a standardised measure), their statistical reliability and validity are questionable. Nonetheless, findings from these studies may tentatively suggest that there is likely to be a negative relationship between burnout and self-care amongst NHS staff.

Self-care in NHS staff delivering psychological interventions is an important research topic, as the roles filled by these staff are regulated by the Health Care Professionals Council (HCPC). The HCPC professional practice guidelines (HCPC, 2016) state that self-care is a core competency and an ethical requirement for safeguarding fitness to practice. Similarly, the BPS professional practice guidelines (BPS, 2008) state that psychologists have a duty to address stress and burnout by practising stress management and personal support techniques to maintain optimum functioning over their professional career. However, the guidelines neither define self-care nor provide practical examples. Subsequently, self-care may be open to interpretation or difficult to apply.

Despite being an ethical requirement for practice, several authors claim that self-care is insufficiently addressed in training and continuing professional development (Barnett & Cooper, 2009; Walsh & Cormack, 1994; Wise et al., 2012), raising concerns that staff may not practise self-care unless they are explicitly trained to do so (Mills et al., 2015). Mills et al. (2015) further argue that it is uncertain whether self-care training is effective when staff lack the capacity to be self-compassionate, as self-care may be neglected if the clinician does not believe that they are as deserving of care as their clients – a feeling that relates to their self-compassion.

1.19 Defining Self-Compassion

Neff's (2003a) definition of self-compassion is the most frequently used in research (MacBeth & Gumley, 2012). Similar to her definition of compassion for others, her definition of self-compassion draws on Buddhist theory and social psychology, suggesting self-compassion consists of three components:

- self-kindness: being kind and understanding towards oneself in instances of pain or failure, rather than being self-critical;
- common humanity: perceiving one's experiences of pain and failure as part of being human, rather than seeing these experiences as separating and isolating; and
- mindfulness: holding painful thoughts and feelings in balanced awareness, rather than avoiding them or overidentifying with them.

Neff (2016) states that self-compassion requires a dynamic balance between compassionate and uncompassionate responses to difficulty. Although these components are separable, they mutually impact each other; thus, a lack of self-compassion is as important to the definition as its presence (Neff, 2015). Neff operationalises her definition of self-compassion through her Self-Compassion Scale (Neff, 2003b), which is described in the Method chapter.

1.20 Self-Compassion and Burnout

As discussed previously, symptoms of depression, anxiety and stress overlap with symptoms of burnout (Teater & Ludgate, 2014). In a meta-analysis of studies involving clinical and non-clinical samples in the UK and USA, MacBeth and Gumley (2012) found a strong negative relationship between self-compassion and depression, anxiety and stress. Relating to therapists specifically, Gilbert, McEwan, Matos and Rivis (2010) found a negative relationship between self-compassion and depression, anxiety and stress in a sample of UK therapists attending a compassion workshop. However, the specificity of the sample (i.e., 59 therapists with a presumed interest in compassion) may limit the generalisability

of the findings. Research by Leary et al. (2007) suggests that self-compassion can attenuate reactions to stress and negative events. In a study of Australian psychologists, Finlay-Jones, Rees and Kane (2015) found a negative predictive relationship between self-compassion and emotion regulation difficulties, stress, anxiety and depression. Furthermore, the study found emotion regulation difficulties mediated the relationship between self-compassion and stress, anxiety and depression. Emotion regulation difficulties were assessed using the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) which defines emotion regulation difficulties as: non-acceptance of emotions, difficulties engaging in goal-directed behaviour when upset, impulse control difficulties, lack of emotional awareness, limited access to emotion regulation strategies and lack of emotional clarity. However, an explanation of causal factors in emotional regulation difficulties was not hypothesised and emotion regulation difficulties seem to be assumed under an umbrella term. From a compassionate mind approach, these difficulties could be related to over-activation of the threat system and under-activation of the soothing system. Furthermore, behaviours associated with emotion regulation difficulties appear to be in direct opposition to self-compassionate behaviour.

Using the Self-Compassion Scale (SCS; Neff, 2003b) and the PRO-QOL (Stamm, 2010), studies of UK counselling and CBT trainees (Beaumont et al., 2016b), UK student midwives (Beaumont et al., 2016a), UK community nurses (Durkin et al., 2016) and US counsellors (Ringenbach, 2009) found a negative relationship between self-compassion and burnout. This relationship has also been observed in other populations, including US clergy (Barnard & Curry, 2012), US medical students (Olson et al., 2015) and Korean students (Kyeong, 2013). This evidence provides strong support for a likely negative relationship between burnout and self-compassion in NHS staff delivering psychological interventions.

1.21 Compassion for Oneself and Others

The Dalai Lama (2003) states that in order to develop compassion for others a person must have compassion for his or her self. Similarly, Gilbert (2005) states

that the capacity to be compassionate towards others is influenced by self-compassion. Following this, self-compassion is likely important for NHS staff, given the current prioritisation of compassionate care. Relating to NHS staff delivering psychological interventions, Gilbert and Leahy (2007) state that compassion for both oneself and one's clients is essential for therapists, and that compassion for clients is only sustainable when compassion for oneself is first achieved. However, empirical research on the relationship between compassion for oneself and compassion for others is mixed, with Welford (2012) suggesting that some people (e.g., victims of abuse) may have high compassion for others yet low self-compassion.

Neff and Pommier (2013) found a small positive relationship between self-compassion and other-focused variables of compassion for humanity, empathetic concern, perspective taking, altruism, less personal distress when confronting the suffering of others and forgiveness in a sample of US community adults. Further, Neff and Germer (2013) found that training in self-compassion increased both self-compassion and compassion for others in a community sample of American adults, supporting the relationship between self-compassion and compassion for others.

Using the Self-Compassion Scale (SCS; Neff, 2003b) and the Compassion for Others Scale (CFO; Pommier, 2011), positive, although not significant, relationships between self-compassion and compassion for others was found in UK counselling and CBT trainees (Beaumont et al., 2016b), student midwives (Beaumont et al., 2016a) and community nurses (Durkin et al., 2016). In these studies, participants showed high levels of compassion for others, yet only moderate levels of self-compassion. From the studies described above, it seems reasonable to hypothesise that self-compassion and compassion for others are positively related. However, the significance of this relationship is unclear.

1.22 Compassion, Burnout and Self-Care

Gilbert and Choden (2015) propose that therapists who provide compassion for others without practising self-compassion are at increased risk of burnout. Both Neff (2003) and Gilbert (2005) suggest that one's ability to be self-compassionate is related to one's ability to practise self-care. Furthermore, Figley (2002) suggests that psychotherapists with higher levels of self-compassion are more likely to engage in concrete acts of self-care. Based on these ideas, a positive relationship between self-compassion and self-care in NHS staff seems likely. However, these claims are made purely on theoretical grounds, rather than empirical evidence. The relationship between care for oneself and care for others is articulated by the Dalai Lama (2003), who states that caring for others requires caring for oneself. Similarly, Gilbert (2005) suggests that one's ability to care for others is likely to be impaired if one is unable to care for oneself. Supporting this, Richards et al. (2010) found that when staff learned a new self-care technique they reported increased wellbeing and were able to treat clients more effectively. This tentatively suggests a positive relationship between self-care and the ability to show compassionate care towards others.

Potentially linking factors of client care, self-care and self-compassion, Rao et al. (2016) found that almost two-thirds of NHS psychological therapy staff reported coming to work when they were too unwell (demonstrating a lack of self-care) to perform their duties (suggesting an impact on client care), with 92% stating that this was due to self-imposed pressure (showing a lack of self-compassion), rather than pressure imposed on them from colleagues or managers. Mills et al. (2015) hypothesise that a deficit in self-care and self-compassion in nurses is likely to result in burnout and compromised compassionate care, whilst an increase in staff self-compassion could both reduce burnout and increase compassionate care.

1.23 Summary of Key Studies

Key studies that have investigated two or more of the variables of compassion, burnout and self-care are summarised in Table 4, which outlines each study's aims, method (e.g., measures used, sample, design, analysis) and main findings, as they relate to the current study. All of the studies involved a survey method, cross-sectional design and quantitative statistical analysis. Therefore, all of the observed relationships are correlational and cannot be assumed to be causal. Further, survey data are subject to the biases associated with self-report data, as stated in the Discussion chapter. Limitations of the studies are indicated in italics. Theses / grey literature are highlighted in grey.

The measures that were used in the current study are indicated in bold typeface. The most frequently used measures are abbreviated and listed below:

- **CFO: Compassion for Others Scale (Pommier, 2011)**
- **MBI-HSS: Maslach Burnout Inventory Human Services Survey (Maslach & Jackson, 1981)**
- PROQOL: Professional Quality of Life Scale (Stamm, 2010)
- SCAW: Self-Care Assessment Worksheet (Saakvitne and Pearlman, 1996)
- **SCS: Self-Compassion Scale (Neff, 2003b)**
- SWEMWBS: Short case load-Edinburgh Mental-Wellbeing Scale (NHS Scotland, 2007)

Table 4. Summary of the Key Studies

Authors (date) Aims	Method: Measures, sample, design, analysis	Main findings *Limitations*
Alkema, Linton and Davies (2008) To investigate the relationship between **self-care**, compassion fatigue, **burnout** and compassion satisfaction in hospice staff.	US – 37 hospice care staff • PROQOL • SCAW Survey, cross-sectional Pearson correlation	Negative relationship between burnout and all forms of self-care: Physical (r=-.311, p=.05) Psychological (r=-.322, p=.05) Emotional (r=-.497, p=.05) Spiritual (r=-.496, p=.05) Workplace (r=-546, p=.05) Balance (r=-.496, p=.05) *SCAW is not a standardised measure and sample size is small, so statistical conclusions may lack reliability and validity.*
Beaumont, Durkin, Hollins Martin and Carson (2016b) To measure associations between **self-compassion**, compassion fatigue, wellbeing and **burnout** in student therapists.	UK – 54 CBT and counselling students • **SCS** • **CFO** • PROQOL • SWEMWS Survey, cross-sectional Pearson correlation Independent *t* test of differences between high self-compassion and low self-compassion	Negative relationship between burnout and self-compassion (r=-.486, p=.01) and compassion for others (r=-.289, p=.05). No significant relationship between self-compassion and compassion for others (r=.061, p=ns). *Convenience sample of third-year students at one university potentially limits generalisability.*
Beaumont, Durkin, Hollins Martin and Carson (2016a) To explore relationships between **self-compassion**, compassion fatigue, wellbeing and **burnout** in student midwives.	UK –103 student midwives • **SCS** • **CFO** • PROQOL • SWEMWS Survey, cross-sectional Pearson correlation	Negative relationship between burnout and self-compassion (r=-.312, p=.01). No significant relationship between burnout and compassion for others (r=-.135, p=ns). No significant relationship between self-compassion and compassion for others (r=.132, p=ns). *Convenience sample of students at one university potentially limits generalisability.*

Durkin, Beaumont, Hollins Martin and Carson (2016) To explore relationships between **self-compassion**, compassion fatigue, wellbeing and **burnout** in community nurses.	UK – 37 community nurses • **SCS** • **CFO** • PROQOL • SWEMWS Survey, cross-sectional Pearson correlation	Negative relationship between burnout and self-compassion (r=-.369, p=.05). No significant relationship between burnout and compassion for others (r=-.041, p=ns). No significant relationship between self-compassion and compassion for others (r=-.191, p=ns). *Convenience sample of nurses studying for a diploma at one university potentially limits generalisability.*
Olson et al. (2015) To explore relationships between **burnout, self-compassion** and empathy in paediatric residents.	US – 45 medical students • **SCS** • **MBI-HSS** • Jefferson Scale of Physician Empathy (Hojat et al., 2001) Survey, cross-sectional Pearson correlation	Significant negative relationship between self-compassion and emotional exhaustion (r=-.35, p=.05). No significant relationship between self-compassion and depersonalisation (r=-.27, p=ns) or personal accomplishment (r=.24, p=ns). No significant relationship between empathy and burnout (EE r=.09, DP r=-.11, PA r=-.03). No significant relationship between empathy and self-compassion (r=.17, p=ns).
Catlin-Rakoski (2012) To investigate relationships between therapist **self-care**, compassion satisfaction, **burnout** and secondary traumatic stress.	US – 46 mental health therapists • SCAW • PROQOL Survey, cross-sectional Pearson correlation	Negative relationship between burnout and all forms of self-care: Physical (r=-.541, p=.01) Psychological (r=-.542, p=.01) Emotional (r=-.586, p=.01) Spiritual (r=-.387, p=.01) Workplace (r=-.614, p=.01) Balance (r=-.557, p=.01) *SCAW is not a standardised measure and sample size is small, so statistical conclusions may lack reliability and validity.*

Martin-Johnson (2016) To explore the relationship between **self-care and burnout**. To explore gender differences in self-care and burnout.	US – 325 mental health staff • Brief COPE (Carver, 1997) • **MBI-HSS** Survey, cross-sectional Multiple regression *t* tests	COPE was significantly predictive of depersonalisation, emotional exhaustion and reduced personal accomplishment. Gender differences in levels of substance use, self-blame, depersonalisation, emotional exhaustion and reduced personal accomplishment. *The Brief COPE Inventory was developed to assess a broad range of coping responses that cannot be assumed to be equivalent to self-care.*
Ringenbach (2009) To compare differences in compassion fatigue, compassion satisfaction, **burnout and self-compassion** in counsellors who meditate with those who do not.	US – 164 counsellors • **SCS** • PROQOL • Marlowe-Crowne Social Desirability Scale-SF (Strahan and Gerbasi, 1972) • Active meditation checkbox + type + months practised • Number of hours of self-care per week Survey, cross-sectional Pearson correlation MANCOVA (controlling for social desirability)	Negative relationship between self-compassion and burnout (r=-.525, p=.01) in all counsellors. Significantly higher levels of self-compassion and lower levels of burnout in meditators (N=62) than non-meditators (N=102). No significant differences in burnout or self-compassion and compassion fatigue in counsellors who reported more than 5 hours of self-care per week vs. those who reported fewer than 5 hours per week. *Frequency of meditation practice was not specified.* *Lack of self-care definition.* *Number of self-care hours per week was likely difficult to estimate.*

1.24 Aims of the Current Study

The overarching aim of this study was to draw together different, yet converging, areas of theory and empirical research on compassion, burnout and self-care, in order to investigate areas that had been theoretically linked but not empirically investigated. The study also aimed at addressing some of the limitations of existing research, including use of purpose designed measures, interchangeable terminology and a failure to conceptualise self-care. Staff burnout and lack of compassionate care in the NHS have been highlighted by the press, and there is a current emphasis in NHS policy on improving both compassionate care and staff wellbeing. Despite this context, the relationships between compassion, burnout and self-care have been under researched.

Following a review of the literature, burnout and compassion for others were selected as dependent (outcome) variables for the research questions. Burnout was selected due to the evidence of a negative impact of burnout on individual staff members, compassionate care and the wider NHS. Compassion for others was selected due to the prioritisation of compassionate care in NHS policy and strategy, yet the lack of empirical research on this topic. Research on self-care was also deemed to be lacking: despite the proclamation that self-care is an ethical and professional requirement for practice, no research had explored self-care amongst NHS staff. Further, no validated measures of self-care were found in the literature. In order to address these gaps, the current study aimed at exploring the ways in which NHS staff practise self-care.

1.25 Research Questions and Hypotheses

Specifically, this study examined the following questions:

Research Question 1. What factors are associated with burnout in NHS staff delivering psychological interventions: self-compassion, compassion for others or self-care?

Hypothesis 1.1

It was hypothesised that burnout would be negatively associated with self-compassion, compassion for others and self-care.

Hypothesis 1.2

It was hypothesised that burnout would be predicted by self-compassion, compassion for others and self-care.

Research Question 2. What factors are associated with compassion for others in NHS staff delivering psychological interventions: burnout, self-compassion or self-care?

Hypothesis 2.1

It was hypothesised that compassion for others would be positively associated with self-compassion and self-care and negatively associated with burnout.

Hypothesis 2.2

It was hypothesised that compassion for others would be predicted by self-compassion, burnout and self-care.

Research Question 3. How do NHS staff delivering psychological interventions practise self-care?

2 METHOD

2.1 Epistemology

Epistemology is the area of philosophy devoted to theories of knowledge and relates to validity and reliability of research (Barker, Pistrang, & Elliott, 2003). Furthermore, consideration of epistemology draws together the areas of research and philosophy, bridging the gap between the scientist practitioner and reflective practitioner models drawn on in the practice of clinical psychology (Dempster, 2011). There is a continuum of epistemological approaches, ranging from realist to relativist positions. A realist approach suggests that there is an objective reality, independent of the person observing it, and that this reality can be proven through the application of scientific tests (Bhaskar, 2008). A relativist approach suggests reality is relative to something else, i.e. the interactions between people and their context, so all perceptions are equally valid and worth exploring (Kuhn, 1996). Within this continuum, there are a range of approaches where differences are more subtle. The most commonly adopted approaches in psychological research are positivist, critical realist and social constructionist approaches (Dempster, 2011). Positivism suggests that the goal of research is to observe and measure phenomenon, to develop and test theories and refine hypotheses in order to obtain an understanding of the relationships between phenomena (Bhaskar, 2008). Social constructionism suggests that there is no single reality that can be studied as reality is what an individual constructs through their interaction with the world (Burr, 2003). Because of this, social constructionism assumes that the researcher cannot be separated from the participant, with data being a product of the interaction between researcher and participant, i.e. the researcher plays an active role in influencing and interpreting data (Burr, 2003). Critical realism acknowledges that a real external world exists, and this has regularities, yet recognises that all our understandings are essentially tentative (Archer et al., 2013). Critical realism acknowledges the impact of researcher bias on interpretation of data. To address this, critical realism emphasises the replicability of research and requires researchers to be explicit about their

methods, results and conclusions in order to facilitate replication and evaluation (Cook, Campbell & Day 1979).

The epistemological stance of the researcher typically determines the methodological approach adopted as different epistemological approaches are associated with different research methodologies. However, there is overlap and different epistemologies are associated with a variety of research methods. Realist approaches are typically associated with experimentation and statistical analysis of quantitative data. In contrast, social constructionist approaches are typically associated with discourse analysis of qualitative data from texts and interviews. This study was conducted from a critical realist approach which adopts a pragmatic approach to research, allowing the use of both quantitative and qualitative methods, depending on the research question (Archer et al., 2013).

2.2   Design

In accordance with the critical realist position, a mixed methods approach was applied in order to benefit from the complementary strengths and weaknesses of quantitative and qualitative approaches in answering multiple research questions (Barker et al., 2015). The mixed methods approach enabled quantitative hypothesis-testing of the relationships between compassion for others, self-compassion and burnout, and it enabled qualitative content analysis for an exploration of the way in which staff practise self-care, allowing a broader range of research questions.

The mixed methods approach is vulnerable to critique as it combines methods with opposing epistemologies (Creswell, 2013). However, some methodologies are more compatible than others (Dempster, 2011). The methodologies used in this study; quantitative statistical analysis and qualitative content analysis, both fit within a critical realist position. Furthermore, the qualitative content analysis aimed to purely describe the different self-care activities stated by participants from a more realist (critical realist) position, opposed to interpreting responses from a relativist position as participant context was unknown. This approach fits

with the other research questions aiming to explore the relationships between compassion for others, self-compassion, burnout and self-care. Conducted from a critical realist position, the study assumed that the constructs of compassion for others, self-compassion and burnout were objectively measurable through use of standardised measures whilst acknowledging the limitations of such measures. In particular, acknowledging that aspects of participants' experiences would not be captured and that responses would be affected by participants' understandings and interpretations of the constructs and questions. Similarly, recognising that the self-care activities and practices objectively listed by participants was dependent on their subjective understanding of the construct of self-care.

Johnson and Onwuegbuzie (2004) suggest another difficulty associated with mixed methods research is the resources required by the researcher in terms of time and understanding of the different methods. However, the researcher received sufficient teaching on both quantitative and qualitative methods, and the timescale for the study was carefully planned.

An online survey method was selected with the aim of recruiting a sufficiently large sample to increase the generalisability of findings, by allowing a convenient completion time for participants. This was particularly important for recruiting busy NHS staff and facilitating access to participants from a wide range of services and geographic locations.

The LimeSurvey online survey platform was used for this purpose, as it was secure, free and open source. LimeSurvey allowed the use of mandatory question functions, which reduced the likelihood of missing data. It also enabled the separation of incomplete and complete data sets and the direct export of data into SPSS (statistical analysis software version 22) for analysis, thus reducing errors associated with data entry and missing data.

The survey was constructed following design recommendations aimed at increasing response rate and ease of completion (Boynton & Greenhalgh, 2004;

Dillman, 2011; Eysenbach & Wyatt, 2002). These included sectioning topics, ensuring a clear layout, using concise language and having an appealing format.

The full survey is presented in Appendix A. The survey began by providing information about the study and a consent form. Following this, the survey consisted of the following sections:

- **Occupational Information:** questions relating to training status, job role and contracted hours;
- **Burnout:** the Maslach Burnout Inventory for Human Services Professions (MBI-HSS; Maslach & Jackson, 1981);
- **Self-Care:** a free textbox asking participants to list of activities, practices and behaviours they do for self-care, and a numerical Likert-scale rating of satisfaction with one's current level of self-care;
- **Self-Compassion:** the Self-Compassion Scale (SCS; Neff, 2003b);
- **Compassion for Others:** the Compassion for Others Scale (CFO; Pommier, 2011); and
- Demographic information: questions relating to age, gender and ethnicity.

2.3   Measures

2.3.1   Burnout

The Maslach Burnout Inventory for Human Services Professions (MBI-HSS; Maslach & Jackson, 1981) was selected due to its established reliability and validity (Lee, et al. 2011). The MBI-HSS consists of 22 statements that describe job-related feelings (e.g., 'I feel emotionally drained from my work'). Participants rate the frequency with which they agree with the given statement using a 7-point Likert scale, ranging from *never* to *everyday*. The scale is scored by separating items into three subscales that operationalise the three aspects of burnout proposed by Maslach et al. (1996): emotional exhaustion (EE), depersonalisation (DP) and reduced personal accomplishment (PA). Maslach et al. (1996) recommend that the subscales be computed separately, rather than combined, due to limited knowledge of the interrelationships between the three aspects of

burnout. The subscales have good reliability (between .71 and .90), and the correlations between subscales are shown in Table 5.

Table 5. Correlations between MBI Subscales

	EE	DP	PA
EE	1	.52	-.22
DP	-	1	-.26
PA		-	1

A high degree of burnout is indicted by high scores on the EE and DP subscales and a low score on the PA subscale. A low degree of burnout is indicated by low scores on the EE and DP subscales and a high score on the PA subscale. The manual categorises scores into high, moderate and low levels of burnout for different occupational groups. The categorisation for 'mental health staff' is based on a sample of 730 North American mental health staff consisting of psychologists, psychotherapists, counsellors, mental health hospital staff and psychiatrists. The categorisation of scores for mental health staff is shown in Table 6. According to the manual, research usually reports the average rating of each subscale, rather than total subscale score.

Table 6. Categorisation of MBI Scores for Mental Health Staff

MBI-HSS subscale	Description	Mean	Standard deviation	Low	Moderate	High
EE	Emotional Exhaustion	16.89	8.90	0–13	14–20	21–54
DP	Depersonalisation	5.72	4.62	0–4	5–7	8–30
PA	Personal Accomplishment	30.87	6.37	0–28	29–33	34–48

2.3.2 Self-Compassion

Neff operationalised her conceptualisation of self-compassion through the development of the Self-Compassion Scale (SCS; Neff, 2003b). The Self-Compassion Scale is the most frequently used instrument in self-compassion

research, due to its established reliability and validity (MacBeth & Gumley, 2012). The SCS uses six subscales to measure the three positive components of self-compassion (i.e., self-kindness, common humanity and mindfulness) and the three factors that oppose self-compassion (i.e., self-judgement, isolation and over identification). The scale consists of 26 statements that describe the way in which people typically react towards themselves in difficult times (e.g., 'When things are going badly for me, I see the difficulties as part of life that everyone goes through'). Participants rate the frequency with which they behave in the stated manner using a 5-point Likert scale ranging from *almost never* to *almost always*. Neff (2003b) concluded that self-compassion is an overarching factor that emerges from the combination of subscale components, rather than an underlying factor. Because of this, a total self-compassion score is computed by reverse scoring the negative subscale items and computing a total mean. The SCS has an internal consistency of .92.

2.3.3 Compassion for Others

Pommier (2011) developed the Compassion for Others Scale (CFO) with the aim of operationalising Neff's (2003b) definition of compassion on the basis of the structure of the Self-Compassion Scale. The CFO consists of 24 statements that describe the way in which people typically act towards others (e.g., 'Sometimes when people talk about their problems, I feel like I don't care'). Sharing the same response format as the SCS, the CFO requires participants to rate the frequency with which they behave in the stated manner, using a 5-point Likert scale ranging from *almost never* to *almost always*. The scale aims at measuring the three positive components of compassion towards others (i.e., kindness, common humanity and mindfulness) and the three components that oppose compassion towards others (i.e., indifference, separation and disengagement). Each subscale contains four items. Overall compassion is calculated by reverse scoring the negative subscales and computing a total mean. Initial validation studies indicated that the scale has good validity and a reliability of .90 (Pommier, 2011); further standardisation and validation studies are currently in press (Neff & Pommier, in press).

2.3.4 Self-Care

Due to the lack of conceptualisation and operationalisation of self-care in the literature, and to begin to explore the way in which staff practise self-care, participants were asked to write (in a free textbox) their answer to the following question: 'Thinking about your life in general, both at and outside of work, please list any activities, practices, behaviours, etc. you do for self-care'.

A quantitative value of self-care was generated by asking staff to rate their satisfaction with their current level of self-care, using a 5-point Likert scale ranging from *strongly disagree* to *strongly agree*, in order to very tentatively explore the relationships between self-care, burnout, self-compassion and compassion for others. A 5-point Likert scale was used as it is one of the most commonly used methods of assessing satisfaction (Dillman, 2011). However, the scale applied here assumed that satisfaction with self-care was equivalent to its use or effectiveness, and this assumption may not be legitimate. Therefore, any conclusions made about the relationship between self-care satisfaction and the other variables should be made tentatively.

2.4 Procedure

2.4.1 Ethical Approval

Ethical approval was granted by the University of East London Ethics Committee prior to recruitment. The ethical approval form is presented in Appendix B.

Confidentiality. Responses were anonymous and confidential. No identifying data were collected. A secure online survey tool was used and data were stored using password-protected files and computers, in accordance with The Data Protection Act (1998) and BPS ethics guidelines for internet-mediated research (BPS, 2013).

Informed consent. Participants had to verify that they had read and understood the information regarding the study before they could begin the survey. Contact details for the researcher, the research supervisor and the

university research integrity and ethics manager were provided in order for participants to have the opportunity to discuss the details of the research and ask questions about the study. Consent was verified at the end of the survey, before participants submitted their responses.

Right to withdraw. Participants were notified that participation in the study was entirely voluntary and that they would be free to withdraw at any time during the survey without disadvantage and without any obligation to provide a reason. It was stated that because the data would be anonymised, they would not be identifiable and therefore could not be withdrawn after they were submitted.

Maximising benefit and minimising harm. The benefits of participating in this study were likely to include contributing to an under researched topic and increasing one's awareness of self-care. Risks of involvement were unlikely. However, participants were advised to seek supervision and/or advice from staff support services in the event that they found certain questions to trigger awareness of any difficulties.

Remuneration. To thank participants for completing the survey, they were offered the option of entering into a prize draw to win one of five £20 Amazon vouchers. To enter the competition, participants had to email an address given at the end of the survey. The prize draw was managed separately from the survey data to ensure confidentiality and anonymity. The five winners were drawn at random using the Microsoft Excel random sample function.

2.4.2 Pilot

The survey was piloted with eight psychologists from a variety of services and roles, who were recruited via the researcher's professional network. Changes to the survey, including the clarification that self-care practice applied both at and outside of work and the addition of the 'save function' so that participants could continue the survey at a later time, were made on the basis of the feedback received in this pilot study. Data from this pilot study were not analysed.

2.4.3 Sampling

Staff were recruited via snowball sampling and social media. NHS staff who were known to the researcher, working in different services and roles across England, were sent an invitation email containing a link to the survey and full information about the study (see Appendix C). The email outlined the inclusion criteria regarding job role/title, and participants were asked to forward the email to colleagues who may be interested in taking part. Survey information was also posted in *The Psychologist* magazine, on the onlinepsychresearch.co.uk and clinpsy.org.uk websites and on the researcher's LinkedIn and ResearchGate pages.

The term 'staff' was used as an umbrella term to refer to the wide range of roles for which the primary training is in 'psychological interventions'. NHS Choices (2016) uses the term 'psychological interventions' to describe a wide range of psychological approaches, including: counselling, cognitive-behavioural therapy (CBT), mindfulness-based therapy, cognitive analytic therapy (CAT), systemic and family therapy, psychodynamic/psychoanalytic psychotherapy, interpersonal therapy (IPT) and eye movement desensitisation and reprocessing (EMDR). Although staff from other professional groups – for example psychiatrists, nurses and social workers – could be described as 'staff delivering psychological interventions', such interventions would not be considered their primary intervention or training method, and thus they were not included in the study sample. Further, self-care is not explicitly stated in the professional guidelines of these groups.

2.4.4 Power Calculation

Statistical power analysis is designed to minimise type II errors by ensuring that a study's sample size is sufficiently large to identify trends in the data (Field, 2013). Field (2013) suggests that a sample size should be derived from prior studies in the field, but this was not possible in the current study due to a lack of empirical research on the relationships between self-compassion, compassion for others, burnout and self-care. Power analysis was conducted using G*Power software (Faul, Erdfelder, Lang & Buchner, 2007), specifying an alpha of 5% and a desired

power of 80%. The sample size needed to obtain adequate power using correlational and regression analyses with the required number of variables was estimated at 68 participants.

2.5   Refining the Hypotheses

The research questions remained consistent but hypotheses 1.1 and 1.2 were refined, as the MBI was selected to measure burnout and the manual for this scale states that the three subscales must be reported separately. Also, self-care satisfaction was used as a proxy measure of self-care due to a lack of existing validated measures. Thus, the hypothesis were refined as follows:

2.5.1   Research Question 1. Factors Associated with Burnout in NHS Staff Delivering Psychological Interventions

Hypothesis 1.1. It was hypothesised that emotional exhaustion and depersonalisation would be negatively associated with self-compassion, compassion for others and self-care satisfaction. Similarly, it was hypothesised that personal accomplishment would be positively associated with self-compassion, compassion for others and self-care satisfaction.

2.5.2   Research Question 2. Factors Associated with Compassion for Others in NHS Staff Delivering Psychological Interventions

Hypothesis 2.1. It was hypothesised that compassion for others would be positively associated with self-compassion, self-care satisfaction and personal accomplishment. It was also hypothesised that compassion for others would be negatively associated with emotional exhaustion and depersonalisation.

3   RESULTS

3.1   Overview of the Data Analysis

Quantitative data analysis was used to explore the factors associated with burnout (Research Question 1) and compassion for others (Research Question 2) in NHS staff delivering psychological interventions. Statistical analysis was conducted using SPSS (statistical analysis software version 22), following the guidance of several statistics texts: those of Field (2013), Howitt and Cramer (2014), Pallant (2016) and Tabachnick and Fidell (2013). Qualitative content analysis was used to explore the ways in which staff practise self-care (Research Question 3), following guidance from Creswell (2013), Elo and Kyngäs (2008), Joffe and Yardley (2004) and Willig (2013).

3.1.1   Data Checking and Cleaning

Burnout, self-compassion, compassion for others and self-care satisfaction were measured using Likert scales, which are considered an ordinal level of measurement. However, although several statistical texts argue that non-parametric statistics are most appropriate for ordinal data, it has become common practice in social and medical sciences research to assume that Likert-type categories constitute interval-level measurement (Jamieson, 2004). Knapp (1990) argues that it is acceptable to treat ordinal scales as interval scales, provided that the sample size is large (200+) and the data are normally distributed. Norman (2010) takes this further, stating that parametric statistics are sufficiently robust to analyse Likert scale data, even with small sample sizes or non-normally distributed data.

Preliminary analyses were performed to assess whether the data met the assumptions of normality, linearity and homoscedasticity required for parametric statistical analysis. This involved comparing means with 5% trimmed means, assessing skewness and kurtosis and using histograms and normal and detrended Q-Q plots. Boxplots were used to check for outliers and extreme outliers, with Tabachnick and Fidell (2013) recommending that extreme outliers

be removed to avoid statistical distortion. Five extreme outliers were removed: three participants with high depersonalisation scores and two participants with low compassion for others scores.

3.2   Participants

A total of 357 participants started the survey. Of these, 210 completed the survey in full. Therefore, 147 participants started the survey but did not complete it. Hypotheses and implications of this are discussed in the Discussion chapter. Five extreme outliers were removed in the initial data screening, resulting in 205 full data sets.

3.2.1   Occupational Information

Occupational information for the sample is shown in Table 7. Participants were asked to select the term – from a list provided by NHS Careers (2016) – that best described their current role or the role they were in training for. The majority of participants (68.8%) were clinical psychologists who were qualified in their current role (76.1%) and working full-time (78%).

Table 7. Occupational Information

	Frequency (*N*)	Percentage of sample (%)
Role	**205**	**100.0**
Clinical psychologist	141	68.8
Counselling psychologist	14	6.8
Psychotherapist	4	2.0
Family therapist	1	0.5
CBT therapist	5	2.4
High intensity therapist	5	2.4
Counsellor	4	2.0
Psychological wellbeing practitioner	13	6.3
Graduate mental health worker	1	0.5
Assistant psychologist	17	8.3

Training status	205	100.0
In training for current role	49	23.9
Qualified in current role	156	76.1
Working hours	**205**	**100.0**
Full-time (37.5 hours/week or more)	160	78.0
Part-time (less than 37.5 hours/week)	45	22.0

3.2.2 Demographic Information

The composition of age, gender and ethnicity is shown in Table 8. Participants were given the option of declining to answer the demographic information questions; however, no participants chose this option. More than half of the participants (55.1%) were aged 26 to 35. The majority of the participants were female (85.4%) and White (94.6%). In terms of gender and ethnicity, the sample was similar to that shown in the BPS 2016 membership data.

Table 8. Demographic Information

	Frequency (*N*)	Percentage of sample (%)
Age	**205**	**100.0**
Under 25	12	5.9
26–35	113	55.1
36–45	47	22.9
46–55	22	10.7
56–65	11	5.4
Gender	**205**	**100.0**
Male	30	14.6
Female	175	85.4
Ethnicity	**205**	**100.0**
White/White British/White other	194	94.6
Mixed race/Multiple ethnic groups	5	2.4
Asian/Asian British/Asian other	2	1.0
Black/African/Caribbean/Black British/Black other	2	1.0
Other	2	1.0

3.3 Descriptive Statistics

Table 9 shows the sample mean, standard deviation (SD), skewness and kurtosis values for the standardised scales used: MBI subscales (Emotional Exhaustion, Depersonalisation and Personal Accomplishment), the Self-Compassion Scale and the Compassion for Others Scale.

Table 9. Descriptive Statistics for the Standardised Scales Used

Measure	Group mean	SD	Skew	Kurtosis
Emotional Exhaustion (MBI-HSS)	2.62	1.21	0.26	-0.58
Depersonalisation (MBI-HSS)	1.00	0.92	1.43	1.83
Personal Accomplishment (MBI-HSS)	4.55	0.75	-0.48	0.08
Self-Compassion (SCS)	3.29	0.67	-0.02	-0.16
Compassion for Others (CFO)	4.15	0.37	-0.81	0.35

In terms of skewness and kurtosis, values of 0 indicate normal distribution. Howitt and Cramer (2014) suggest that skewness and kurtosis values between -1 and +1 indicate normal distribution, whereas George and Mallery (2010) suggest that values between -2 and +2 should be used to prove normal distribution. Tabachnick and Fidell (2013) suggest that with large samples (of more than 200 participants), skewness and kurtosis do not make a substantive difference in the analysis. In the present study, the only measure that showed a questionable normal distribution was the Depersonalisation subscale of the MBI-HSS, which had skewness (1.43) and kurtosis (1.83) values indicating clusters in the low range.

3.3.1 Burnout

Scores relating to burnout were categorised according to the MBI manual. The mean total score for the Emotional Exhaustion subscale was 23.58, indicating high levels of emotional exhaustion. The mean total score for the Depersonalisation subscale was 4.99, with a score of 5 indicating moderate levels of depersonalisation. The mean total score for the Personal Accomplishment subscale was 36.40, indicating high levels. More than half of the staff (56.1%) reported high levels of emotional exhaustion. However, the majority of staff also reported low levels of depersonalisation (59%) and high levels of personal accomplishment (70.2%). Table 10 shows group mean subscale totals and the percentage of staff scoring within the different categories of burnout, as defined by the MBI manual.

Table 10. Mean MBI Subscale Score Totals and Categorisations

Subscale	Mean subscale total (category)	% of sample in each category		
		Low	Moderate	High
Emotional Exhaustion	23.58 (high)	20.5%	23.4%	56.1%
Depersonalisation	4.99 (low/moderate)	59.0%	19.0%	22.0%
Personal Accomplishment	36.40 (high)	10.7%	19.1%	70.2%

3.3.2 Self-Compassion

Neff (2015) suggests that average self-compassion scores tend to be around 3.0. She suggests that scores: between 1 and 2.5 indicate low self-compassion; between 2.5 and 3.5 indicate moderate self-compassion; and between 3.5 and 5.0 indicate high self-compassion. However, these are very rough categorisations, and the categories overlap (e.g., 2.5 can indicate both low and moderate self-compassion). As there is no concise categorisation of scores, the scores in this study were not categorised. The mean self-compassion score in this study was 3.29, indicating moderate self-compassion. Average self-

compassion scores in the sample ranged from 1.2 (indicating low self-compassion) to 4.9 (indicating high self-compassion).

3.3.3 Compassion for Others

Categorisations of scores on the Compassion for Others Scale were not available, as the standardisation and validation paper had not yet been published (Neff & Pommier, in press). The mean Compassion for Others score in this study was 4.15. This is likely to indicate high levels of compassion for others, given that the maximum score on this scale is 5. Average Compassion for Others scores in the sample ranged from 3.0 to 4.8.

3.3.4 Self-Care Satisfaction

Responses to the statement 'I am satisfied with my current level of self-care' are shown in Table 11.

Table 11. Satisfaction with Self-Care

'I am satisfied with my current level of self-care'	Frequency (*N*)	Percentage of sample (%)
Strongly disagree	6	2.9
Disagree	61	29.8
Neutral	9	4.4
Agree	109	53.2
Strongly agree	20	9.8

Results indicated that 63% of participants were satisfied with their current level of self-care and 32.7% were not satisfied.

3.4   Correlation Analysis

Correlation analysis was used to investigate the associations between burnout and self-compassion, compassion for others and self-care satisfaction, in order to test hypothesis 1.1. The associations between compassion for others and self-compassion, burnout and self-care satisfaction were also investigated using correlation analysis, in order to test hypothesis 1.2. Howitt and Cramer (2014)

suggest that, in psychological research, it is often difficult to determine whether parametric assumptions have been violated. Thus, they recommend that researchers compare the results of Pearson (parametric) and Spearman's rho (non-parametric) correlations. They further recommend that, if the results are broadly similar, the Pearson correlation be used, as this enables the use of more powerful statistical techniques. The Pearson and Spearman's rho results were compared and found to be very similar, so the Pearson correlation was used to explore the relationships between the variables. The results of this correlation are shown in Table 12. All correlations were significant at the 0.01 level (one-tailed).

Table 12. Pearson Correlations

	EE	DP	PA	SCS	CFO	SCSAT
EE	1	.503	-.336	-.491	-.288	-.436
DP	-	1	-.315	-.355	-.472	-.243
PA	-	-	1	.382	.388	.302
SCS	-	-	-	1	.305	.460
CFO	-	-	-	-	1	.189
SCSAT	-	-	-	-	-	1

3.5   Research Question 1. Factors Associated with Burnout in NHS Staff Delivering Psychological Interventions

3.5.1 Hypothesis 1.1

It was hypothesised that emotional exhaustion and depersonalisation would be negatively associated with self-compassion, compassion for others and self-care satisfaction. Similarly, it was hypothesised that personal accomplishment would be positively associated with self-compassion, compassion for others and self-care satisfaction.

Hypothesis 1.1 was accepted, as emotional exhaustion was negatively associated with self-compassion (r=-.491, p=.01), self-care satisfaction (r=-.436, p=.01) and compassion for others (r= -.288, p=.01). Depersonalisation was negatively associated with self-compassion (r=-.355, p=.01), compassion for others (r=-.472, p=.01) and self-care satisfaction (r=-.243, p=.01). Personal

accomplishment was positively associated with self-compassion (r=.383, p=.01), compassion for others (r=3.88, p=.01) and self-care satisfaction (r=.302, p=.01).

3.5.2 Hypothesis 1.2

It was hypothesised that burnout would be predicted by self-compassion, compassion for others and self-care.

The MBI characterises burnout as high emotional exhaustion, high depersonalisation and low personal accomplishment. Conducting multiple analyses on the data increases the risk of a type I error, wherein a hypothesis is accepted as true despite it actually being false (Field, 2013). In order to reduce the number of analyses and minimise the risk of type I error, hypothesis 1.2 was refined to focus on the emotional exhaustion aspect of burnout. The rationale for this focus was that emotional exhaustion has been cited as the most prevalent aspect of burnout in mental health staff (S. Johnson et al., 2012) Onyett & Mui, 1997; Prosser et al., 1996). This finding was replicated in the current sample, scoring high on emotional exhaustion yet low on depersonalisation and high on personal accomplishment. Hypothesis 1.2 was refined as follows:

3.5.3 Hypothesis 1.2

It was hypothesised that emotional exhaustion would be predicted by self-compassion, compassion for others and self-care satisfaction.

3.6   Regression Analysis

Standard – or simultaneous – multiple regression was used to investigate the predictive ability of self-compassion, compassion for others and self-care satisfaction on emotional exhaustion. Standard multiple regression was conducted following the guidance provided by Field (2013) and Tabachnick and Fidell (2013) and selected due to the lack of evidence in the literature specifying the existence of known relationships, which would have been required for hierarchical multiple regression. Preliminary analyses were conducted to ensure no violation of the assumptions of normality, linearity, multicollinearity and

homoscedasticity. Collinearity diagnostics were used to check for multicollinearity. Normal distribution was checked using a normal P-P plot and a scatterplot. Potential outliers were investigated through the Mahalanobis distance and Cook's distance measures.

The R-squared value indicated the degree to which variance in emotional exhaustion was explained by self-compassion, compassion for others and self-care satisfaction. In the present study, the R-squared value (R-squared=0.314, F=30.687, p=.01) indicated that 31.4% of the variance in emotional exhaustion was explained by self-compassion, compassion for others and self-care satisfaction. This value included the unique contribution of each variable, plus the influence of shared variance. The regression model reported standardised coefficient beta values, indicating the predictive strength of each variable. Providing that the values were significant, the largest beta value indicated the variable that made the strongest unique contribution to explaining emotional exhaustion when the variance explained by the other variables in the model was controlled for. The unique contribution of each variable to the total R-squared value was calculated by squaring the part correlation coefficients.

Hypothesis 1.2 was accepted. Self-compassion was the strongest predictor of emotional exhaustion (beta=-.330, p=0.01), uniquely explaining 8.1% of the variance in emotional exhaustion. Self-care satisfaction also predicted emotional exhaustion (beta=-.258, p=0.01), uniquely explaining 5.2% of the variance. Compassion for others was the weakest predictor of emotional exhaustion (beta=-.139, p=.03), uniquely accounting for 1.7% of the variance in emotional exhaustion.

In summary, hypothesis 1.1 was accepted, as emotional exhaustion and depersonalisation were negatively associated with self-compassion, compassion for others and self-care satisfaction. Similarly, personal accomplishment was positively associated with self-compassion, compassion for others and self-care satisfaction. Hypothesis 1.2 was accepted, as emotional exhaustion was predicted by self-compassion, compassion for others and self-care satisfaction.

3.7 Research Question 2. Factors Associated with Compassion for Others in NHS Staff Delivering Psychological Interventions

3.7.1 Hypothesis 2.1

It was hypothesised that compassion for others would be positively associated with self-compassion, self-care satisfaction and personal accomplishment. It was also hypothesised that compassion for others would be negatively associated with emotional exhaustion and depersonalisation.

Correlation analysis, as shown in Table 12, was used to investigate the associations between compassion for others and burnout, self-compassion and self-care satisfaction, in order to test hypothesis 2.1.

Hypothesis 2.1 was accepted, as compassion for others was positively associated with self-compassion (r=.305, p=.01), self-care satisfaction (r=.189, p=.01) and personal accomplishment (r=.388, p=.01). Compassion for others was also negatively associated with depersonalisation (r=-.472, p=.01) and emotional exhaustion (r=-.288, p=.01).

3.7.2 Hypothesis 2.2

It was hypothesised that compassion for others would be predicted by self-compassion and burnout.

Standard – or simultaneous – multiple regression was used to investigate the predictive ability of self-compassion, burnout (emotional exhaustion, depersonalisation, personal accomplishment) and self-care satisfaction on compassion for others, in order to test hypothesis 2.2.

The R-squared value indicated the degree to which variance in compassion for others was explained by self-compassion, the three aspects of burnout and self-care satisfaction. The R-squared value (R-squared=0.292, F=16.436, p=.01) indicated that 29.2% of the variance in compassion for others was explained by self-compassion, the three aspects of burnout and self-care satisfaction. This

measure included the unique contribution of each variable, plus the influence of shared variance. The largest significant beta value indicated the variable that made the strongest unique contribution to explaining compassion for others when the variance explained by the other variables in the model was controlled for. The unique contribution of each variable to the total R-squared value was calculated by squaring the part correlation coefficients.

Depersonalisation was the strongest predictor of compassion for others (beta=-.376, p=0.01), uniquely explaining 12.5% of the variance in compassion for others. Compassion for others was also predicted by personal accomplishment (beta=.244, p=.01), which uniquely accounted for 6.4% of the variance. Self-compassion (beta=.092, p=NS), emotional exhaustion (beta=.028, p=NS) and self-care satisfaction (beta=-.008, p=NS) did not uniquely predict variance in compassion for others.

In summary, hypothesis 2.1 was accepted, as compassion for others was positively associated with self-compassion and personal accomplishment and negatively associated with emotional exhaustion and depersonalisation. However, hypothesis 2.2 was only partially accepted, as compassion for others was predicted by depersonalisation and personal accomplishment but not self-compassion, emotional exhaustion or self-care satisfaction.

3.8 Research Question 3. How NHS Staff Delivering Psychological Interventions Practise Self-Care

3.8.1 Qualitative Content Analysis

There is overlap between qualitative content analysis (Elo & Kyngäs, 2008) and thematic analysis (Braun & Clarke, 2006), with the terms 'theme' and 'category' often used interchangeably (Joffe & Yardley, 2004). Vaismoradi, Turunen and Bondas (2013) state that qualitative content analysis is appropriate for describing responses to short open-ended survey questions, whereas thematic analysis is more appropriate for interpreting large quantities of text data, such as interview sets. Qualitative content analysis (rather than in-depth interviews) was selected

for pragmatic reasons, in order to generate insight into staff practice. This was deemed important, as no studies had investigated the way in which NHS staff practised self-care.

Deductive qualitative content analysis aimed at condensing the self-care activities listed by participants into the broad dimensions of self-care that had been proposed in the US literature: physical, psychological, spiritual, social and professional self-care. The analysis process followed the recommendations of Elo and Kyngäs (2008), with the unit of analysis selected as words and/or short phrases. The data were reviewed for content and coded according to correspondence with the dimensions of self-care. Coding involved writing the different practices of self-care onto Post-it notes and placing them into one of the five categories. Participants often duplicated activities. These duplicated activities and frequency counts were not recorded, as the range and diversity of activities – rather than the frequency with which they were practised – was the focus of the research question. The raw data responses to the question 'Thinking about your life in general, both at and outside of work, please list any activities, practices, behaviours, etc. you do for self-care' are presented in Appendix D.

Within each dimension, activities were further categorised into subcategories, in order to summarise the large number of activities into a more concise and accessible format. This process was conducted through inductive content analysis, following the process described by Elo and Kyngäs (2008). The activities within each dimension were collapsed into broader subcategories, on the basis of similarity and difference. Subcategories were named using content-characteristic words. Table 13 shows the way in which NHS staff practised self-care based on the five primary categories outlined above, as well as the subcategories within these dimensions. The activities are listed alphabetically in accordance with participant responses, with duplicate activities removed.

Table 13. How NHS Staff Practise Self-Care

	Subcategories	Self-Care activities
Physical	Meeting basic needs and routine activities	attending medical appointments, chores, cooking, early nights/sleep, eating well/healthily, food, keeping house tidy, looking after physical health, rest, sex
	Exercise and sport	cycling, dancing, exercise, football, gym, Pilates, running, swimming, team sports, walking, yoga
	Being outdoors and with nature	being by the sea, being in the sun, being outdoors, gardening, time with animals/pets
	Having time away/out	day trips, doing nothing, holidays, relaxation, short breaks
	Hobbies and leisure	art, baking, cinema, crafts, DIY, gaming, gigs, hobbies, internet, leisure, listening to music, playing music/instruments, reading novels/magazines, shopping, singing, social media, theatre, watching sport, watching TV
	Pampering and comforting activities	alcohol/drinking, baths, beauty treatments, massage, tea/coffee
Psychological	Mindfulness	3-minute breathing space, mindful activities, mindfulness
	Compassion	accepting compliments, compassionate mind exercises, positive affirmations, practicing compassion, reducing self-criticism, self-kindness
	CBT techniques	CBT techniques, cognitive restructuring, problem solving
	Personal therapy	personal therapy
	Self-awareness and reflection	challenging unrealistic expectations and perfectionism, journal writing, perspective taking, self-awareness and reflection
	Emotional expression and regulation	cry, humour, laugh, self-soothing, shout
Spiritual	Spiritual practice	belonging to a spiritual community, Buddhist practice, connecting with spirituality, going to church/chapel, meditation, retreats
	Solitude	solitude, time alone
Social	Spending time with…	Friends, family, partner, children
	Expressing self to…	Friends, family, partner
Professional	Work/life balance	annual leave/taking time off, flexi time, having a work/life balance, keeping to contracted hours, leaving on time, not working late/evenings/weekends, not taking work home, taking sick leave when needed, TOIL, turning off work phone and email, working part-time
	Formal support	consultation, CPD and training, individual supervision, peer supervision, peer support groups, reflective practice groups
	Informal support	chatting with colleagues, lunch with colleagues, moaning/venting to colleagues, support from colleagues,
	Structuring work	allocating time for admin/notes and session preparation, balanced caseload of clients, desk space, lunch breaks, maintaining boundaries, not checking email too frequently, pacing workload, prioritising work, regular breaks, setting limits, time management

3.8.2 Data Checking

Raw data, coding, dimensions and subcategories were checked by two raters in order to ensure reliability (Graneheim & Lundman, 2004). This was particularly important as the inductive content analysis used to generate the subcategories was based on the researchers' interpretation of the data. However, in general, reliability checks do not establish that codes are objective, but merely suggest that two people might apply the same subjective perspective to the text (Joffe & Yardley, 2004).

4   DISCUSSION

This chapter begins by briefly describing how the findings answer the research questions and hypotheses. The findings are then discussed in greater depth in relation to existing research and implications for clinical practice. Limitations of the study are highlighted and directions for future research are suggested.

4.1   Overview of the Research Questions and Findings

Research Question 1. What factors are associated with burnout in NHS staff delivering psychological interventions: self-compassion, compassion for others or self-care?

Findings: Burnout was negatively associated with self-compassion, compassion for others and self-care satisfaction**.**

Research Question 2. What factors are associated with compassion for others in NHS staff delivering psychological interventions: burnout, self-compassion or self-care?

Findings: Compassion for others was negatively associated with burnout and positively associated with self-compassion and self-care satisfaction.

Findings of the study relating to burnout, compassion for others, self-compassion and self-care will be discussed in turn, relative to the existing literature. Relationships between the variables will then be critically evaluated in relation to the existing literature.

4.2 Overview of Burnout, Compassion for Others, Self-Compassion and Self-Care in NHS Staff Delivering Psychological Interventions

4.2.1 Burnout

Previous research has cited emotional exhaustion as the most prevalent cause of burnout in mental health staff (Johnson et al., 2012; Onyett & Mui, 1997; Prosser et al., 1996). This finding was replicated in the current study, with participants scoring high on emotional exhaustion yet low on depersonalisation and high on personal accomplishment. Previous research has failed to propose an explanation for this finding, although personal accomplishment relates closely to job satisfaction (Maslach et al., 2001) and high levels of job satisfaction have frequently been found in therapists (Norcross & Guy, 2007).

High emotional exhaustion with high personal accomplishment and low depersonalisation may also be explained by the work of Freudenberger (1974), who suggests that burnout in helping professionals relates to their over commitment to their work at the expense of their own needs. MBI statements corresponding to emotional exhaustion relate to the negative impact on the clinician, rather than a cost to the client (e.g., 'I feel emotionally drained from my work'). Another hypothesis that potentially explains findings of low depersonalisation and high emotional exhaustion is that MBI statements corresponding to depersonalisation suggest an opposition to ethical standards of practice and potentially risk harm to clients (e.g., 'I feel I treat some clients as if they were impersonal objects'). Despite the anonymity of responses, participants may not have been willing to acknowledge their agreement with this statement.

4.2.2 Compassion for Others

Current NHS policy is focused on compassionate care, despite the lack of a standardised measurement for this variable (Papadopoulos & Ali, 2015). This study used the Compassion for Others Scale to measure compassionate care, but scores on this scale cannot be assumed to be directly related to or equivalent to scores reflecting compassionate care. Thus, the potential for the findings to inform our knowledge of compassionate care in practice is limited.

Given that the maximum mean score of the Compassion for Others Scale is 5, the mean score of 4.2 that was found in this study appears high and is comparable to mean scores that were found in previous UK studies of trainee therapists (Beaumont et al., 2016b), student midwives (Beaumont et al., 2016a) and community nurses (Durkin et al., 2016). High levels of compassion for others was anticipated, given the nature of the participants' work. Although empathy is not equivalent to compassion for others, significantly higher levels of empathy have been found in healthcare staff than in the general population (Beddoe & Murphy, 2004). Future research might find it useful to compare these means with those of the general UK population. Unfortunately, no such norms exist, but US norms are currently in press (Neff & Pommier, in press).

4.2.3 Self-Compassion

The average self-compassion score in US norms is 3 (Neff, 2003b). The mean self-compassion score for the participants in the current study was 3.3. This indicates that participants had moderate levels of self-compassion, which is comparable to the means found in UK trainee therapists (Beaumont et al., 2016b), student midwives (Beaumont et al., 2016a) and community nurses (Durkin et al., 2016).

4.2.4 Self-Care Satisfaction

One of the major limitations of this study was the use of a 5-point Likert rating of staff satisfaction, using current level of self-care satisfaction as a proxy measure of self-care. This was due to a lack of existing standardised measures of self-care. Satisfaction with current level of self-care cannot be assumed to be directly related to or equivalent to self-care. Because self-care satisfaction is not a valid measurement of self-care, conclusions based on statistical analyses using this measure lack validity and reliability, and should be drawn tentatively.

The relationships between burnout, compassion for others, self-compassion and self-care are discussed next, in relation to the findings of this study. The findings are also related to the existing theoretical and empirical literature.

4.3 Factors Associated with Burnout and Compassion for Others in NHS Staff Delivering Psychological Interventions

4.3.1 Burnout and Self-Care

Several authors claim that self-care is the most important factor in preventing or reducing therapist burnout (Barnett et al., 2007; Good et al., 2009; Malinowski, 2014; Smith and Moss, 2009). Using the SCAW, a negative association between burnout and all dimensions of self-care was found in US hospice staff (Alkema et al., 2008) and US mental health therapists (Catlin-Rakoski, 2012), although small sample sizes and the use of the SCAW potentially limit the validity and reliability of these findings. Although self-care satisfaction is not equivalent to self-care, the current study supports previous theoretical and empirical research by finding a negative relationship between burnout and self-care satisfaction, as shown by a strong negative association between emotional exhaustion and depersonalisation and self-care satisfaction, and a positive association between personal accomplishment and self-care satisfaction. This suggests that staff with higher levels of satisfaction with their self-care had lower levels of burnout and staff with lower levels of satisfaction with their self-care had higher levels of burnout. Self-care satisfaction was a significant predictor of emotional exhaustion.

Catlin-Rakoski (2012) and Alkema et al. (2008) found professional self-care to be most strongly associated with lower levels of burnout, and a large variety and frequency of professional self-care strategies (e.g. supervision and peer support) were cited in this study. Teater and Ludgate (2014) suggest that preventative measures against therapist burnout include strong personal and professional/peer social support networks, work/life balance, supervision and self-awareness. These strategies were all cited as self-care activities in the current study. As sense of satisfaction is a common component of both self-care satisfaction and personal accomplishment. This may partially explain the finding of a positive relationship between personal accomplishment and self-care satisfaction.

4.3.2 Burnout and Self-Compassion

Self-compassion has been proposed as a protective factor against staff burnout (Mills et al., 2015). A negative association between burnout and self-compassion has been consistently found in research involving mental health staff (Beaumont et al., 2016; Ringenbach, 2009), healthcare staff (Beaumont et al., 2016a; Durkin et al., 2016) and other populations, such as clergy (Barnard & Curry, 2012) and students (Kyeong, 2013). These findings were replicated in the current study, which found a negative relationship between burnout and self-compassion, as indicated by a strong negative association between emotional exhaustion and depersonalisation and self-compassion, and a positive association between personal accomplishment and self-compassion. Self-compassion was the strongest predictor of emotional exhaustion. This suggests that staff with higher levels of self-compassion had lower levels of burnout and staff with lower levels of self-compassion had higher levels of burnout. This finding supports the conclusion of the existing literature suggesting that self-compassion protects against staff burnout by preventing over identification with (or depersonalising) client distress and encouraging staff to value themselves and their work (Mills et al., 2015).

4.3.3 Burnout and Compassion for Others

The current study found a negative relationship between burnout and compassion for others, as indicated by a negative association between emotional exhaustion and depersonalisation and compassion for others, and a positive association between personal accomplishment and compassion for others. Compassion for others was a weak but significant predictor of emotional exhaustion, and was most strongly predicted by depersonalisation. These findings suggest that staff with higher levels of burnout had lower compassion for others and staff with lower levels of burnout had higher compassion for others.

The strong negative relationship between depersonalisation and compassion for others was expected, as MBI statements corresponding to depersonalisation (e.g., 'I don't really care what happens to some clients') are in direct opposition to those relating to compassion for others (e.g., 'I don't think too much about the

concerns of others' is reverse scored). Compassion for others was also predicted by personal accomplishment. This was expected, as several MBI statements corresponding to personal accomplishment (e.g., 'I can easily understand how my clients feel about things') overlap with those relating to compassion for others (e.g., 'When I see someone feeling down, I feel like I can't relate to them', which is reverse scored). However, while compassion for others was predicted by depersonalisation and personal accomplishment, it was not predicted by emotional exhaustion. This could have been due to emotional exhaustion relating to negative symptoms experienced by the therapist (e.g., 'I feel used up at the end of the work day') rather than general feelings of compassion for others.

The literature regarding the relationship between burnout and compassion for others is mixed. Staff burnout has been proposed as a factor resulting in a lack of compassionate care (Francis, 2013), which is tentatively supported by this study. However, Figley (2002) suggests that therapists with greater compassion for others are at greater risk of burnout, due to overidentification with client distress. Although findings are tentative, this theory is not supported by this study. The empirical research is also mixed. Beaumont et al. (2016b) found a negative relationship between burnout and compassion for others in UK trainee therapists, but this relationship was not significant in samples of student midwives (Beaumont et al., 2016a) or community nurses (Durkin et al., 2016).

4.3.4 Compassion for Others and Self-Care

Conclusions about the relationship between compassion for others and self-care must be made tentatively. Theoretically, it has been suggested that the ability to care for others is impaired when one is unable to care for oneself (Dali Lama, 2003; Gilbert, 2005). However, compassion for others is not equivalent to caring for others, nor is self-care satisfaction equivalent to self-care. This study found a positive association between compassion for others and self-care satisfaction. This suggests that staff with higher satisfaction with their self-care had higher levels of compassion for others and staff with lower satisfaction with their self-care had lower levels of compassion for others. Compassion for others was not

predicted by self-care satisfaction. Future research on self-care and compassion for others – or, more specifically, compassionate care – is recommended.

4.3.5 Compassion for Others and Self-Compassion

Theoretically, the ability to show compassion for others is related to the ability to be self-compassionate (Dalai Lama, 2003; Gilbert, 2005; Neff, 2003a). The current study supports this theory, finding a positive relationship between compassion for others and self-compassion. This suggests that staff with higher levels of self-compassion had higher levels of compassion for others and staff with lower levels of self-compassion had lower levels of compassion for others. Self-compassion did not independently predict compassion for others, which suggests that there might have been an interaction effect with other variables. Also, the relationship between compassion for others and self-compassion was not found to be significant in previous studies of UK therapists (Beaumont et al. 2016b), student midwives (Beaumont et al., 2016a) and community nurses (Durkin et al., 2016), although these findings were not explained.

4.3.6 Self-Compassion and Self-Care

Neff (2003a) and Gilbert (2005) suggest that the ability to practise self-care is related to the ability to be self-compassionate. Figley (2002) suggests that self-compassionate therapists are more likely to practise self-care. Mills et al. (2015) propose that staff are less likely to practise self-care if they lack the ability to be self-compassionate. However, no empirical research has investigated this theory, and it was not explicitly investigated in this study, due to the lack of a validated measure of self-care. However, the current study found a positive relationship between self-care satisfaction and self-compassion. This suggests that staff with high levels of self-compassion were more satisfied with their self-care and staff with lower levels of self-compassion were less satisfied with their self-care. Self-compassion involves acceptance and satisfaction with oneself, and this could explain this positive relationship. Further research on self-compassion and self-care is recommended.

4.4 Relating Findings to the Compassionate Mind Approach

Burnout is hypothesised to be due to chronic activation of the threat system (Cole-King & Gilbert, 2011). Compassion shown to oneself and others and many of the self-care activities cited (e.g., meditation, mindfulness, social support) are likely to reduce activation of the threat and drive systems and increase activation of the soothing system (Gilbert, 2009). This could potentially explain the negative relationships found between burnout and compassion for others, self-compassion and self-care satisfaction.

4.5 How NHS Staff Delivering Psychological Interventions Practise Self-Care

The self-care activities that were reported in this study appear to correspond with the dimensions of self-care that were proposed by Malinowski's (2014) review of the US literature: physical, psychological, spiritual and social (personal and professional). The subcategories of self-care, as proposed by the current study, are summarised in Table 14. All of the self-care activity groupings summarised by Malinowski (2014) and Brownlee (2016) were replicated in the current data, and additional activity groupings – or subcategories – were revealed.

Table 14. Summary of Self-Care Dimensions and Subcategories

Self-Care Dimension	Subcategories (summary of activities)
Physical	Meeting basic needs and routine activities
	Exercise and sport
	Being outdoors and with nature
	Hobbies and leisure
	Pampering and comfort activities
Psychological	Mindfulness
	Compassion
	CBT techniques
	Personal therapy
	Self-awareness and reflection
	Emotional expression and regulation
Spiritual	Spiritual practice
	Solitude
Social	Spending time with friends, family, partner, children
	Expressing oneself to friends, family, partner
Professional	Work/life balance
	Formal support
	Informal support
	Structuring work

In relation to the 12-principle model of self-care proposed by Norcross and Guy (2007), few participants described a need to prioritise self-awareness and self-care, recognise occupational hazards and evaluate work. However, these aspects of self-care could be more closely related to participants' definition of, rather than practise of, self-care.

Although frequency of activities was not assessed in the current study (as the focus of the research question was the range and diversity of activities), there was a noticeable preference for physical and professional self-care activities in the current sample, in terms of both range and frequency. This would be useful to explore further, as the finding differs from the conclusions of a study of US counsellor self-care by Catlin-Rakoski (2012), which found spiritual self-care to be the most engaged form of self-care, followed by physical and psychological

self-care, respectively. The benefits of physical self-care are well-established (Malinowski, 2014). The regulation of supervision, management and working hours in the NHS, compared to US private healthcare systems, may account for the greater range and frequency of professional self-care activities in this study. Several activities that were cited in the current study overlap with those on the Self-Care Assessment Worksheet (SCAW; Saakvitne & Pearlman, 1996), which has been used to measure self-care in US studies. However, some activities on the SCAW (e.g., 'love yourself', 'social action', 'be curious', 'have experiences of awe') were not cited in this study. Also, the full range of activities listed in the current study is not captured by the SCAW (e.g., 'alcohol/drinking', 'keeping to contracted hours', 'compassionate mind exercises'). This supports the decision not to use the SCAW in this study, as, in addition to not being a validated measure, its relevance to NHS staff is questionable.

Almost two-thirds of participants (63%) were satisfied with their current level of self-care, compared with one-third (32.7%) of staff who were not satisfied. The literature suggests that therapists are poor at self-care (Figley, 2002; Kennerley, Mueller, & Fennell, 2010; Norcross & Guy 2007; Teater & Ludgate, 2014), yet the majority of participants in this study were satisfied with their level of self-care. However, ratings of satisfaction with self-care in this study were likely dependent on the way in which participants defined self-care and the value or importance they placed on it, and these factors were not assessed. Several participants also commented 'not enough' or 'need for improvement' in response to questions about their current level of self-care.

Data gathered in this study could lead to further research aimed at developing and validating a measure of staff self-care for NHS staff. Another area for future research could be a more detailed exploration of staff self-care through the use of interviews or focus groups and qualitative analysis. Finally, staff's definition of self-care would be a useful subject for future research, given that self-care is stated as an ethical requirement for practice (HCPC, 2016) but is not defined within professional guidelines.

4.6   Limitations

The limitations of this study include the lack of a validated measure of self-care and the inability to generalise the finding regarding compassion for others to the more specific matter of compassionate care. Researcher bias must be explicitly acknowledged, as confirmatory bias is likely to have influenced the research design and data interpretation by seeking confirming rather than disconfirming evidence. This means potentially seeking evidence to support the hypothesised relationships between compassion for others, self-compassion, burnout and self-care, rather than seeking evidence to disconfirm such relationships. However, Proctor and Capaldi (2008) state that researcher confirmatory bias is extremely common in psychological research. They further suggest that providing the research question is relevant, the design is adequate and the data are clearly and comprehensively described, then the findings should not be viewed prejudicially, regardless of whether they conform to current theoretical predictions. Other limitations of the current study include biases associated with the use of self-report questionnaires and correlational data that prevents conclusions of causation.

4.6.1   Limitations Associated with Self-Report Questionnaires

The MBI, Self-Compassion Scale and Compassion for Others Scale use a closed response Likert scale. Biases associated with Likert scales include acquiescence bias, wherein participants simply agree with statements in the measure, and extreme responding, wherein answers tend towards the extreme points of the scale. The closed response format of the measures used in this study potentially failed to fully capture participants' full experience of burnout, self-compassion and compassion for others, as participants likely had different understandings of these concepts. In order to address this limitation, a textbox was included at the end of the survey to enable participants to comment on the survey or clarify their responses. However, no participants made use of this textbox. Future research could employ interviews or focus groups and qualitative methods in order to

explore the ways in which staff experience burnout, self-compassion and compassion for others.

Participant responses – particularly those regarding depersonalisation and compassion for others – may have been influenced by professional expectations or social desirability, leading participants to suppress unfavourable responses. A measure of social desirability bias was not included in this study, due to the length of the survey, and it was hoped that the anonymity and confidentiality of the survey responses would encourage participants to respond honestly.

A potential ethical limitation of the online survey was that the researcher was not present to observe the participants responding, and thus she could not monitor the emotional state of the participants. To address this, the study information sheet at the start of the survey clearly indicated that risks of involvement were unlikely, but that some participants may find that certain questions trigger an awareness of difficulties they may be experiencing. Participants who experienced this were encouraged to seek supervision and/or advice from staff support services.

4.6.2 Limitations Associated with Sampling

Respondent bias likely influenced this study, as staff with stronger views about the subject may have been more likely to partake in the research. Survey completion, in general, is affected by levels of participant motivation (Dillman, 2011). As burnout is associated with exhaustion and a lack of motivation, staff with higher levels of burnout may have been less likely to complete the survey. 147 participants started the survey, but did not complete it. One hypothesis is that participants were deterred by the length of the survey, with the opening section clearly stating that the survey would take approximately 10-15 minutes to complete. This may have been particularly likely if participants were experiencing high levels of burnout as burnout is associated with low energy, concentration and motivation. Another possible explanation is that participants started the survey and saved it with the intention of completing it at a later date.

Unfortunately, a reminder function was not available as responses were anonymous and confidential. An exact closing date was not stated, as this was dependent on an adequate sample size being obtained. Therefore, the survey may have been closed before participants were able to complete it. This has been taken as a learning point for future research.

This study supported the wider literature that self-care is a protective factor against staff burnout. Two thirds of participants reported being satisfied with their self-care. This contrasted with the existing literature hypothesising therapists are poor at self-care. If staff experiencing higher levels of burnout and lower levels of self-care were deterred from completing the survey due to its length, then sampling bias may have resulted in self-care satisfaction being overestimated and burnout, self-compassion and compassion for others being underestimated.

The results could have also been potentially confounded by group differences in compassion, burnout and self-care across demographic and occupational groups. Data were gathered in the current study regarding age, gender, ethnicity, trainee status, role and contracted hours. However, small subgroup numbers limited the opportunity to investigate group differences using post-hoc statistical analyses. The majority of studies evaluated in the literature review did not investigate (or report) group differences. Where these were reported, there was mixed evidence regarding group differences in compassion, burnout and self-care. Thus, a priori hypotheses about group differences were beyond the scope of this study.

The majority of the participants were White (94.6%), female (85.4%) and between 26 and 45 years old (78%). These characteristics could potentially limit the generalisability of the results in the wider population, but they are demographically representative of UK clinical psychologists (BPS, 2015), and the majority of study participants (68.8%) held this profession. However, homogeneity within this 94.6% White sample cannot be assumed. Although ethnicity data was gathered, data regarding nationality or religion of participants was not collected due to constraints on the length of the survey relating to response rate. The ethnic category of 'White/White British/White Other' was

extremely broad so whether or not participants identified more with collectivist or individualistic culture was unknown, for example this category would include 'British Buddhist' and 'Irish Catholic' – with these groups in no way considered homogenous.

There is mixed evidence about gender differences in burnout in mental health staff. Some studies have reported higher levels of burnout in female than in male staff (Hannigan et al., 2004); however, this may be related to underreporting in males – perhaps as a result of ideas about masculinity – and the dominance of females in mental health professions. Other studies have found no significant gender differences in burnout in mental health staff (Linley & Joseph, 2007; Ringenbach, 2009). Females tend to show slightly higher compassion for others and slightly lower self-compassion than do males, with Neff and Pommier (2013) hypothesising that this may be due to gender stereotypes. Although younger age has been associated with burnout (Cushway & Tyler, 1996), it is unclear whether the cause of this is indeed age or lack of experience, as coping skills that are gained through experience can reduce burnout, and staff who experience burnout may leave the profession (Nelson, Johnson, & Bebbington, 2009; Stamm, 2010). Trainees have reported higher levels of burnout relative to qualified staff, and this is hypothesised to be due to the additional demands of academic work and assessment during training (Cushway & Tyler, 1996). The type of mental health service that one works in appears to have little effect on level of burnout, as high levels of staff burnout have been found across a range of mental health services. However, as studies have tended to focus on staff within one service type, it is difficult to generalise findings across services (Morse et al., 2012).

4.6.3 Limitations Associated with Correlational Data

A major limitation of this study is that the findings are correlational, and thus they cannot imply causation. The study's cross-sectional design provides a snapshot of staff experience that is likely dependent on context; for example, external stressors such as a thesis deadline or CQC visit may have impacted participants' experiences. As the standardised measures that were used in this study did not indicate a referential time period, participant responses were likely to have been

affected by both memory bias and the current context. A longitudinal design was beyond the scope of the current study, but it would be a useful direction for future research.

A second potentially useful direction for future research would involve the use of more complex statistics to investigate different relationships between variables, such as mediation and moderation effects. However, such an investigation was beyond the scope of the current study, due to the lack of more complex statistical analysis software.

4.7   Implications for Future Research

Directions for future research have been suggested throughout this chapter. This study suggests that there are relationships between burnout, compassion for others, self-compassion and – potentially – self-care.

4.7.1 Future Research on Compassionate Care

Firth-Cozens and Cornwell (2009) suggest that further research on defining and assessing compassion and compassionate care is needed to inform NHS policy for practice. Mills and Chapman (2016) recommend further research – involving both quantitative and qualitative methods – to examine the relationships between staff self-care, burnout, self-compassion and compassion for others and the way in which these factors impact patient satisfaction and outcomes.

4.7.2 Future Research on Compassion from Others

As mentioned at the beginning of this study, compassion is theorised to flow in three directions: towards others, towards the self and from others (Gilbert, 2005; Neff, 2003). Gilbert et al. (2017) suggest that each of these directions has psychological and physiological effects and influences the others.

It may be useful to investigate the three aspects of compassion in relation to staff burnout, self-care and the subsequent ability to deliver compassionate care, as Gilbert et al. propose that high compassion towards and from others is

associated with high self-compassion and self-care, and these have been shown to be protective factors against burnout. On the other hand, high compassion towards others and low compassion from others may be related to defensive, submissive or compulsive caregiving, in addition to low self-compassion, lack of self-care and increased risk of burnout. Compulsive caregiving emphasises the importance of giving care, rather than receiving care, in relationships. This pattern stems from role reversal in the parent–child relationship, and it has been shown to be more likely to present itself in healthcare staff than the general population (Tillett, 2003). The ability to receive compassion and care from others may be related to the utilisation of social support (Gilbert et al.), which was frequently cited in this study and previous literature as a form of self-care and a protective factor against burnout (Malinowski, 2014) in mental health staff.

In order to research the different aspects of compassion and their interactions, Gilbert et al. recently finalised the 'Compassionate Engagement and Action Scales', which aim at measuring the three flows of compassion using three scales corresponding to self-compassion, the ability to be compassionate to distressed others and the ability to receive compassion from key persons in the respondent's life. Each scale consists of two sections. The first section contains six items that reflect the six compassion attributes of the CMT model: sensitivity to suffering, sympathy, non-judgement, empathy, distress tolerance and care for wellbeing. The second section consists of four items that reflect specific compassionate actions that deal with distress. Participants are asked to rate each statement according to the frequency with which they take each action on a scale of 1 to 10 (ranging from *never* to *always*). Initial validation studies using UK, US and Portuguese non-clinical samples have demonstrated good psychometric properties in the measures. Gilbert et al. are currently researching how compassion training can influence these three aspects of compassion.

4.8   Implications for Practice: Reducing Burnout and Increasing Compassion

The literature review suggests that burnout and compassion for others are influenced by both individual and systemic factors. Several authors, including Maslach et al. (2001), have argued that interventions aimed at reducing burnout should target an organisational, rather than individual, level, as environmental factors (e.g., workload and team conflict) have been found to be stronger predictors of burnout than have individual factors. In a review of the literature, Morse et al. (2012) found only eight studies investigating burnout prevention or reduction strategies in mental health staff, including CBT, supervision and support groups. All of these strategies were cited as self-care activities in the current study. All studies showed a reduction in staff burnout but failed to distinguish burnout prevention from reduction, which cannot be assumed to be equivalent (Morse et al., 2012). Morse et al. highlighted several limitations of the studies, including conclusions that were difficult to generalise, small convenience samples of unspecified mental health staff and cross-sectional (rather than longitudinal) designs. They concluded that there is a lack of controlled research leading to implementation and evaluation of organisational interventions to reduce burnout.

A research project led by NHS England (2014) titled 'Building and Strengthening Leadership – Leading with Compassion' suggests that a multifaceted approach, targeting individual, management, team and organisational levels, is needed to sustain compassionate care. The research suggests that organisations should listen to the experiences of patients and staff, clearly define values in behavioural terms and incorporate these values into practice. The research also highlights the need to show staff that they are valued, as this increases retention and enables staff to act compassionately. Haslam (2015) suggests that discussion about compassion should be part of supervision and team meetings, and that compassionate leadership is essential for creating and maintaining compassionate organisations. Staff delivering psychological interventions are well-placed to practise compassionate leadership, with the BPS (2010)

emphasising leadership as a core competency of psychologists, in addition to an understanding of systemic theory, group dynamics and the compassionate mind approach. Staff delivering psychological interventions are also well-placed to deliver mindfulness-based and compassion-focused interventions, which have a growing evidence-base showing effectiveness for reducing staff stress and increasing compassion.

4.8.1 Mindfulness-Based Interventions

As discussed, there is both distinction and overlap between mindfulness and compassion, as mindfulness is a component of both self-compassion and compassion for others. Mindfulness has previously been identified as a form of therapist self-care (Shapiro et al., 2005) and it was frequently cited as a self-care activity in the current study.

Mindfulness-based interventions have been shown to be effective at reducing stress and distress, increasing self-compassion and other-focused concern and improving the therapeutic alliance in UK trainee therapists (Boellinghaus, Jones & Hutton, 2013; Rimes & Wingrove, 2011). Wise et al. (2012) suggest that mindfulness can allow therapists to remain focused and present when dealing with client distress and to prevent over identification, emotional exhaustion and burnout. Egan et al. (2016) propose that mindfulness is likely to increase the ability of staff to practically identify and enact compassion in everyday clinical practice. Boellinghaus, Jones and Hutton (2014) reviewed the literature on the effectiveness of mindfulness-based interventions for increasing clinician self-compassion and other-focused concern. Boellinghaus et al. concluded that mindfulness-based interventions were effective at increasing self-compassion and reducing stress and burnout in healthcare professionals, but that the effect on other-focused concern was unclear. The researchers hypothesised that this may be because healthcare professionals show high levels of other-focused concern, resulting in a ceiling effect; thus, they suggested that more sensitive measures are needed. Boellinghaus et al. also highlighted the need for further research in this area due to the limitations of studies to date, which have involved

small convenience samples, different interventions of differing durations using different outcome measures and lack of follow-up.

Interventions based on acceptance and commitment therapy (ACT) combine mindfulness with values-based actions (Hayes, Strosahl, & Wilson, 1999). Stafford-Brown and Pakenham (2012) found that an ACT intervention was effective at reducing distress, increasing self-compassion and improving therapist efficacy and the working alliance in Australian clinical psychology trainees. A large-scale implementation and evaluation project of brief on-site ACT interventions has demonstrated the potential to improve staff self-care, work/life balance and mental health, and to reduce sick leave (Flaxman, Bond & Livheim, 2013).

4.8.2 Schwartz Rounds

The team (or service) level intervention of Schwartz Rounds is gathering an evidence-base. Schwartz Rounds are inclusive multidisciplinary meetings aimed at reducing staff stress and improving compassionate care through focused discussions on the emotional aspects of caring. The discussions emphasise shared values and a common humanity, rather than separation and hierarchy (Thompson, 2013). Schwartz Rounds have been evaluated in the US and been found to demonstrate improved teamwork, increased empathy, reduced staff stress and improved patient care (Lown & Manning, 2010). They have also been introduced into some NHS Trusts, where evaluation has replicated the positive findings seen in the US (Goodrich, 2012).

4.8.3 Using Supervision to Promote Compassion and Care

Firth-Cozens and Cornwell (2009) emphasise the importance of role modelling compassion towards colleagues in order to show them how to practise compassion towards their clients and themselves. Supervision is a mandatory requirement for NHS staff delivering psychological interventions, and it aims at ensuring the delivery of quality care (HCPC, 2016). It has been consistently identified as a form of self-care and a protective factor against practitioner burnout (Skovholt & Trotter-Mathison, 2011), and it was frequently cited as a

self-care activity in this study. However, conflict with supervisors has been shown to be associated with staff burnout (Rupert et al., 2015). The compassionate mind approach can be used to illustrate the process of supervision as both a risk and a protective factor against burnout. For example, if a supervisee perceives supervision as threatening, his or her threat system will be activated and this will lead to a reduced willingness to disclose vulnerabilities in practice. Potentially, this could lead to suboptimal client care. However, supervisors who model compassion encourage self-compassion and self-care in their supervisee, and this might improve the wellbeing of the supervisee and improve his or her practice by encouraging confidence in admitting vulnerabilities and increasing willingness to take on new challenges (Beaumont & Hollins Martin, 2016). Relating to this, seeking professional and personal support has been frequently identified as a form of self-care (Figley, 2002; Malinowski, 2014), and it was frequently cited as a self-care activity in this study. Linking this inclination to the compassionate mind approach, Walsh and Cormack (1994) suggest that psychologists will be reluctant to seek support if they perceive this request as threatening (i.e., something that will activate the threat system). The researchers suggest that perception of seeking support as threatening is related to organisational devaluation of supportive work practices and fear of being a client. Fear of being a client could be reduced by increasing compassion, and thus fostering a stronger focus on common humanity. In this way, supportive work practices could be part of a compassionate working environment.

4.8.4 Training in Compassion

Spandler and Stickley (2011) suggests that selection for careers delivering psychological interventions can prioritise academic abilities over compassionate qualities, and that there is a lack of specific teaching on compassion during healthcare staff training. Russell (2014) states that competition for training places and assessment-focused training programmes are likely to activate trainees' threat and drive systems, rather than their soothing system. The current NHS context is likely to activate the threat and drive systems in staff, due to performance and outcome monitoring, combined with job uncertainty (Cole-King & Gilbert, 2011).

Mills and Chapman (2016) suggest that healthcare training should involve explicit curricula to educate trainees about compassion and to prepare them experientially for compassionate practice. Egan et al. (2016) suggest that workplace education on compassion, self-compassion and self-care could be a form of caring for staff, enabling them to better care for their patients within a more compassionate environment.

Ballant and Campling (2011) claim that compassionate mind training (CMT) would be an appropriate and accessible intervention aimed at reducing staff burnout, increasing self-compassion and improving compassionate care in the NHS. CMT has been shown to increase self-compassion and compassion for others and to reduce stress and distress in clinical and non-clinical populations (Gilbert & Procter, 2006; Leaviss & Uttley, 2015; Neff & Germer, 2013). In this study, several participants cited compassionate mind exercises and practices as self-care activities. Beaumont and Martin (2016) argue that because mental health staff bear witness to the trauma of others, they are likely to benefit from CMT, which is gathering an evidence-base as an effective intervention for primary trauma (Lee & James, 2013). CMT has also been demonstrated as an effective intervention for reducing self-criticism (Gilbert & Proctor, 2006), which has been associated with therapist burnout (Skovholt & Trotter-Mathison, 2011). Finally, compassion-focused approaches have been found to be effective at reducing the negative impact of perfectionism (Egan et al., 2014), which was found to increase the risk of burnout in Australian clinical psychologists (D'Souza, Egan, & Rees, 2011). Norcross and Guy (2007) suggested that the restructure of cognitions – particularly perfectionism – is a form of therapist self-care. Consistent with this, several participants in the current study cited challenging unrealistic expectations and perfectionism as a self-care activity.

Beaumont and Hollins Martin (2016) proposed a compassionate mind training model for trainee therapists. The model is shown in Figure 5 and could easily be applied to the wide range of NHS staff roles delivering psychological interventions. The model highlights that training demands can activate the threat

system, potentially leading to burnout, and that CMT interventions could reduce burnout and enhance compassion.
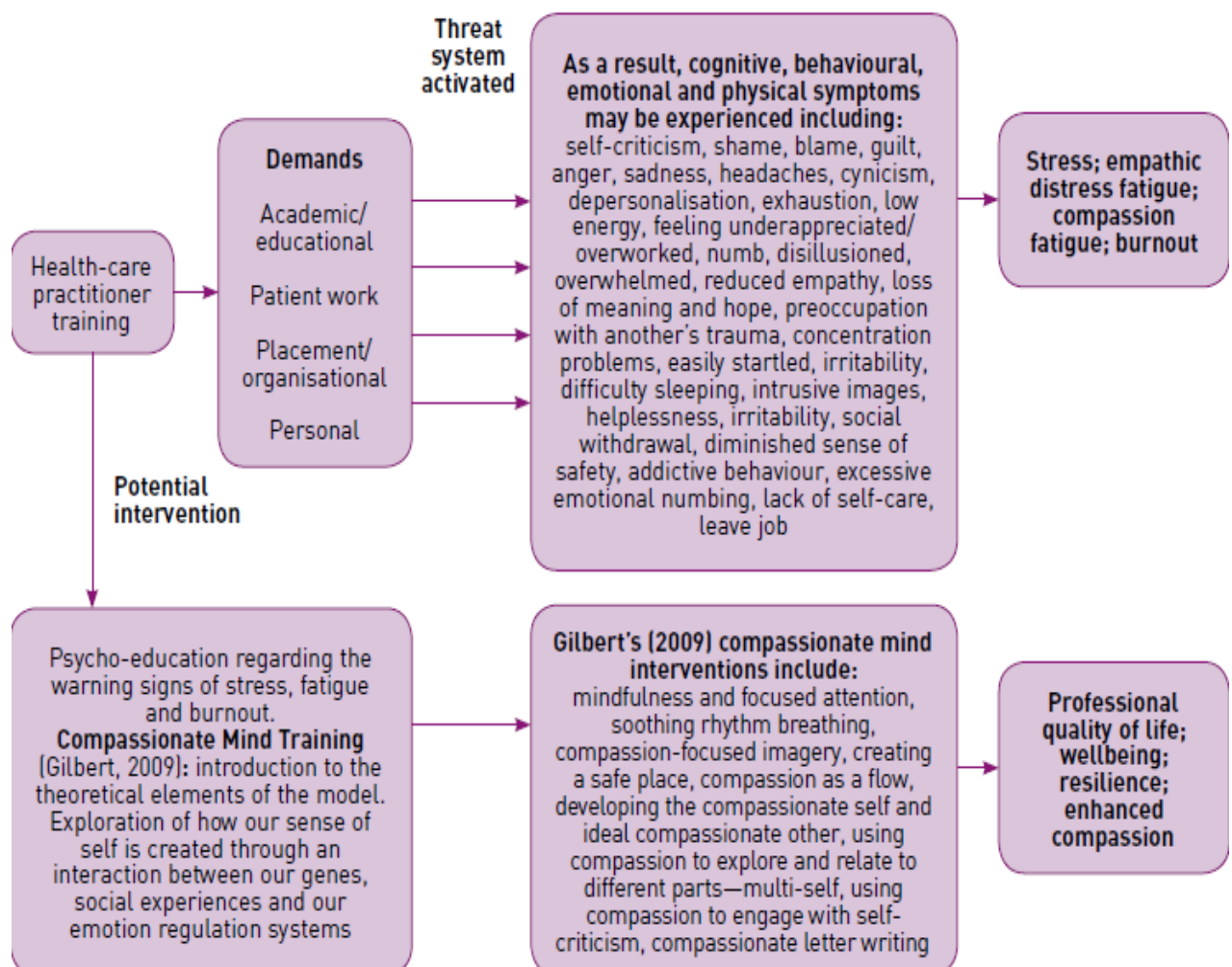
Figure 5. Compassionate mind training model for trainee therapists (Beaumont & Hollins Martin, 2016).

Beaumont and Hollins Martin (2016) highlight the importance of considering the ethical implications of implementing CMT as part of staff training, as compassion-focused interventions have the potential to trigger threat responses, including grief about a lack of care in childhood (Gilbert, 2005). This is particularly important when CMT is administered with therapists, who tend to have higher rates of childhood difficulties than the general population (Ballatt & Campling, 2011). The researchers suggest careful planning of CMT interventions for therapists, incorporating assessment and a safe learning environment (Beaumont & Hollins Martin, 2016).

The CMT training model involves therapists engaging practically in CMT exercises and techniques, such as mindfulness and imagery. Experiential practice of techniques has been shown to improve therapist confidence and effectiveness at using these techniques with clients (Bennett-Levy et al., 2001). This could be an additional benefit of CMT training with therapists, given the growing evidence-base of the efficacy of compassion-focused therapy for a range of mental health problems (Leaviss & Uttley, 2015).

Beaumont et al. (in press) piloted the CMT training model on 21 trainee CBT therapists. The trainees showed significant post-course increases in self-compassion but no significant increases in compassion for others. The researchers suggested that further research should follow-up with larger samples. They also claimed that a more sensitive measure of compassion for others is needed.

Before implementing any form of training aimed at reducing burnout or increasing compassion or self-care, staff beliefs that are likely to influence engagement with the intervention should be explored. For example, Kennerley et al. (2010) suggest that the belief that self-care is optional and that therapists are immune to stress can prevent self-care in CBT therapists. Similarly, the belief that self-compassion is selfish and that one's own needs are not important can prevent both self-care and self-compassion (Welford, 2012), and thus increase the risk of burnout.

4.9 Feedback and Dissemination

The study has already received significant positive interest, and many participants emailed their support and appreciation for research on this topic and requested a copy of the final research. A summary article will be sent to these participants, once complete. Four colleagues invited me to present a CPD session of my research at their respective services. Each session ran for one hour and included a summary of this study and an overview of the literature on compassion, burnout and self-care. The presentations were interspersed with experiential self-care activities and reflection, including group discussions about how the service could better support staff self-care. The end of each session was used for feedback and questions, and the feedback gathered was extremely positive. On the basis of the ideas generated in the sessions, my own service later allocated a specific lunch room for staff and a weekly lunchtime yoga session.

4.10 Reflexivity

My interest in the topics of compassion, burnout and self-care developed following a personal experience of burnout. During this time, I noticed that I was encouraging clients to practise self-care and self-compassion, yet I was not practising these behaviours, myself. Rather, I was working longer hours to keep up with my workload, and this reduced the time I needed to look after myself. I felt like a hypocrite and criticised myself for behaving in this way. Through taking time away from the profession and engaging in personal therapy, I was encouraged to show care and compassion to myself. This had a huge benefit, both personally and professionally, enabling me to return to work with greater motivation and to recognise the values that had initially drawn me to the profession. Being open with friends who also worked in the profession made me realise that I was not alone in my experience. This was the inspiration behind this research.

It is important to recognise the influence of my personal and professional experience on the design, implementation and interpretation of this research. Researcher confirmatory bias has been discussed. However, experiencing the positive impact that increasing self-compassion had on reducing my own state of burnout is likely to have added to this confirmatory bias. My familiarity with the compassionate mind approach may have led to some assumptions going without question and some constructs not being fully critiqued.

As discussed, lack of exploration into the diversity of the sample is a limitation of this study. This may relate to my own agnosticism, potentially leading to lack of investigation into the role of religion and spirituality on compassion, burnout and self-care. This would be a useful area of future research.

In terms of epistemology and methodology, my undergraduate degree was in Natural Sciences at Cambridge University, where the dominant approach to research was a positivist or realist approach using quantitative methodology. In contrast, my doctorate degree in Clinical Psychology was at the University of East London, where the majority of my cohort adopted a social constructionist approach and qualitative methodology. Experiencing both approaches may have influenced my epistemological position of critical realism and my choice of mixed methods.

4.11 Conclusions

Relating back to the aims of the research, this study found a negative relationship between burnout and self-compassion, compassion for others and self-care satisfaction in NHS staff delivering psychological interventions. The study also found positive relationships between compassion for others, self-compassion and self-care satisfaction. Therefore, this study provides preliminary support for theories suggesting that self-compassion and self-care may reduce staff burnout and improve compassion for others.

Participants cited a wide range of self-care activities across physical, psychological, spiritual, social and professional dimensions. Around one-third of staff reported dissatisfaction with their self-care, and it is hoped that this study provided staff with further ideas for self-care activities.

The limitations of this study – particularly the lack of a standardised measure of self-care – were highlighted. Furthermore, directions for future research, such as the development of measures of self-care and compassionate care, were suggested. The concepts of burnout, compassion, self-care and compassionate care would be useful to explore in greater depth using qualitative methods.

The compassionate mind approach was presented as a useful framework for formulating and addressing compassion, burnout and self-care in NHS staff. Compassionate mind training (Gilbert, 2009) may be a suitable intervention and a form of staff self-care that could potentially reduce burnout and increase compassion for oneself and others.

REFERENCES

Akers, J. & Centre for Reviews and Dissemination (CRD), University of York. (2009). *Systematic reviews: CRD's guidance for undertaking reviews in health care.* York: CRD, University of York.

Alkema, K., Linton, J. M., & Davies, R. (2008). A study of the relationship between self-care, compassion satisfaction, compassion fatigue, and burnout among hospice professionals. *Journal of Social Work in End-of-Life & Palliative Care, 4*(2), 101–119. doi:10.1080/15524250802353934

Angermeyer, M. C., Bull, N., Bernert, S., Dietrich, S., & Kopf, A. (2006). Burnout of Caregivers: A Comparison Between Partners of Psychiatric Patients and Nurses. *Archives of Psychiatric Nursing*, *20*(4), 158–165. https://doi.org/10.1016/j.apnu.2005.12.004

Archer, M., Bhaskar, R., Collier, A., Lawson, T., & Norrie, A. (2013). *Critical realism: Essential readings.* Routledge.

Ballatt, J. & Campling, P. (2011). *Intelligent kindness: Reforming the culture of healthcare.* London: RCPsych Publications.

Barker, C., Pistrang, N., & Elliott, R. (2015). *Research methods in clinical psychology: An introduction for students and practitioners* (3rd edition). Malden, MA: Wiley-Blackwell.

Barnard, L. K. & Curry, J. F. (2012). The relationship of clergy burnout to self-compassion and other personality dimensions. *Pastoral Psychology, 61*(2), 149–163. doi:10.1007/s11089-011-0377-0

Barnett, J. E., Baker, E. K., Elman, N. S., & Schoener, G. R. (2007). In pursuit of wellness: The self-care imperative. *Professional Psychology: Research and Practice, 38*(6), 603–612. doi:0.1037/0735-7028.38.6.603

Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016a). Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in student midwives: A quantitative survey. *Midwifery, 34*, 239–244. doi:10.1016/j.midw.2015.11.002

Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016b). Measuring relationships between self-compassion, compassion fatigue, burnout and

well-being in student counsellors and student cognitive behavioural psychotherapists: A quantitative survey. *Counselling & Psychotherapy Research, 16*(1), 15–23. doi:10.1002/capr.12054

Beaumont, E. & Hollins Martin, C. J. (2016). A proposal to support student therapists to develop compassion for self and others through compassionate mind training. *The Arts in Psychotherapy, 50*, 111–118. doi:10.1016/j.aip.2016.06.005

Beaumont, E., Rayner, G., Durkin, M., & Bowling, G. (in press). The Effects of Compassionate Mind Training on Student Psychotherapists. Retrieved from https://www.researchgate.net/

Beck, A. T. (1979). *Cognitive therapy of depression.* Guilford Press.

Bennett-Levy, J., Turner, F., Beaty, T., Smith, M., Paterson, B., & Farmer, S. (2001). The value of self-practice of cognitive therapy techniques and self-reflection in the training of cognitive therapists. *Behavioural and Cognitive Psychotherapy, 29*(02), 203–220.

Bhaskar, R. (2008). *A realist theory of science.* London & New York, NY: Verso.

Boellinghaus, I., Jones, F. W., & Hutton, J. (2014). The role of mindfulness and loving-kindness meditation in cultivating self-compassion and other-focused concern in health care professionals. *Mindfulness, 5*(2), 129–138. doi:10.1007/s12671-012-0158-6

Boynton, P. M., & Greenhalgh, T. (2004). Selecting, designing, and developing your questionnaire. *British Medical Journal, 328*(7451), 1312–1315.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.

British Psychological Society (2008). *Generic Professional Practice Guidelines.* Retrieved from http://beta.bps.org.uk/

British Psychological Society (2010). Clinical Psychology Leadership Development Framework Retrieved from http://beta.bps.org.uk/

British Psychological Society (2013). *Ethics Guidelines for Internet-Mediated Research.* Retrieved from http://beta.bps.org.uk/

British Psychological Society (2016). *Membership Data 2016.* Retrieved from http://beta.bps.org.uk/

Brownlee, E. (2016). How Do Counsellors View and Practise Self-Care. *Healthcare Counselling and Psychotherapy Journal*. April 2016.

Brucato, B. & Neimeyer, G. (2009). Epistemology as a predictor of psychotherapists' self-care and coping. *Journal of Constructivist Psychology, 22*(4), 269–282. doi:10.1080/10720530903113805

Burr, V. (2003). *Social constructionism* (2nd edition). London & New York, NY: Routledge.

Carr, A. (2008). *What Works with Children, Adolescents, and Adults?: A Review of Research on the Effectiveness of Psychotherapy*. Routledge.

Catlin-Rakoski, S. (2012). *Therapist's perceptions of self-care* (Counselor Education Master's Theses). Retrieved from http://digitalcommons.brockport.edu/edc_theses/123.

Cole-King, A. & Gilbert, P. (2011). Compassionate care: The theory and the reality. *Journal of Holistic Healthcare, 8*(3), 29–37.

Cook, T. D., Campbell, D. T., & Day, A. (1979). *Quasi-experimentation: Design & analysis issues for field settings* (Vol. 351). Boston, MA: Houghton Mifflin.

Coster, J. S. & Schwebel, M. (1997). Well-functioning in professional psychologists. *Professional Psychology: Research and Practice, 28*(1), 5–13. doi:10.1037/0735-7028.28.1.5

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches*. SAGE.

Cushway, D. & Tyler, P. (1996). Stress in clinical psychologists. *International Journal of Social Psychiatry, 42*(2), 141–149. doi:10.1177/002076409604200208

Dalai Lama. (2003). *Transforming the mind: Teachings on generating compassion* (new edition). London: Thorsons.

Dempster, M. (2011). *A Research Guide for Health and Clinical Psychology*. Palgrave Macmillan.

Department of Health (2012) *Compassion in Practice* (Publication). Retrieved from https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

Department of Health (2015). *Compassionate Care in the NHS* (Publication). Retrieved from https://www.gov.uk/government/policies/compassionate-care-in-the-nhs

Dillman, D. A. (2011). *Mail and Internet surveys: The tailored design method – 2007 update with new Internet, visual, and mixed-mode guide*. John Wiley & Sons.

D'Souza, F., Egan, S. J., & Rees, C. S. (2011). The relationship between perfectionism, stress and burnout in clinical psychologists. *Behaviour Change, 28*(01), 17–28.

Durkin, M., Beaumont, E., Hollins Martin, C. J., & Carson, J. (2016). A pilot study exploring the relationship between self-compassion, self-judgement, self-kindness, compassion, professional quality of life and wellbeing among UK community nurses. *Nurse Education Today*, *46*, 109–114. https://doi.org/10.1016/j.nedt.2016.08.030

Edwards, D., Hannigan, B., Fothergill, A., & Burnard, P. (2002). Stress management for mental health professionals: A review of effective techniques. *Stress and Health, 18*(5), 203–215. doi:10.1002/smi.947

Egan, H., Mantzios, M., & Jackson, C. (2016). Health Practitioners and the Directive Towards Compassionate Healthcare in the UK: Exploring the Need to Educate Health Practitioners on How to be Self-Compassionate and Mindful Alongside Mandating Compassion Towards Patients. *Health Professions Education.*

Egan, S. J., Wade, T. D., Shafran, R., & Antony, M. M. (2014). *Cognitive-behavioral treatment of perfectionism*. New York, NY: Guilford Press.

Elo, S. & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107–115.

Emery, S., Wade, T. D., & McLean, S. (2009). Associations among therapist beliefs, personal resources and burnout in clinical psychologists. *Behaviour Change*, *26*(02), 83–96.

Eysenbach, G. & Wyatt, J. (2002). Using the Internet for surveys and health research. *Journal of Medical Internet Research, 4*(2).

Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and

biomedical sciences. *Behavior Research Methods, 39*(2), 175–191. doi:10.3758/BF03193146

Fernando, A. T. & Consedine, N. S. (2014). Beyond compassion fatigue: The transactional model of physician compassion. *Journal of Pain and Symptom Management, 48*(2), 289–298.

Field, A. (2013). *Discovering statistics using IBM SPSS statistics* (4th edition). Los Angeles, CA: SAGE.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology, 58*(11), 1433–1441. doi:10.1002/jclp.10090

Figley, C. R. (2013). *Compassion Fatigue: Coping With Secondary Traumatic Stress Disorder In Those Who Treat The Traumatized*. Routledge.

Finlay-Jones, A. L., Rees, C. S., & Kane, R. T. (2015). Self-compassion, emotion regulation and stress among Australian psychologists: testing an emotion regulation model of self-compassion using structural equation modeling. *PLoS ONE, 10*(7), 1–19. doi:10.1371/journal.pone.0133481

Firth-Cozens, J., & Cornwell, J. (2009). *Enabling compassionate care in acute hospital settings*. London: The King's Fund.

Flaxman, P. E., Bond, F. W., & Livheim, F. (2013). *The mindful and effective employee: An acceptance and commitment therapy training manual for improving well-being and performance*. New Harbinger Publications.

Fox, D., Prilleltensky, I., & Austin, S. (2009). *Critical Psychology: An Introduction*. SAGE.

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* London: The Stationery office.

Freudenberger, H. J. (1974). Staff burn-out. *Journal of Social Issues, 30*(1), 159–165. doi:10.1111/j.1540-4560.1974.tb00706.x

Garman, A. N., Corrigan, P. W., & Morris, S. (2002). Staff burnout and patient satisfaction: Evidence of relationships at the care unit level. *Journal of Occupational Health Psychology, 7*(3), 235.

George, D. & Mallery, P. (2010). *SPSS for Windows step by step: A simple guide and reference, 17.0 update*. Allyn & Bacon.

Gerber, Z., Tolmacz, R., & Doron, Y. (2015). Self-compassion and forms of concern for others. *Personality and Individual Differences, 86*, 394–400. doi:10.1016/j.paid.2015.06.052

Gerhardt, S. (2014). *Why love matters: How affection shapes a baby's brain*. Routledge.

Germer, C. K. (2009). *The mindful path to self-compassion: Freeing yourself from destructive thoughts and emotions*. Guilford Press.

Gilbert, P. (2005). *Compassion: Conceptualisations, research and use in psychotherapy*. London & New York, NY: Routledge.

Gilbert, P. (2009). *The compassionate mind* (re-issue edition). Robinson.

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, *53*(1), 6–41.

Gilbert, P. (2010). An introduction to compassion focused therapy in cognitive behavior therapy. *International Journal of Cognitive Therapy, 3*(2), 97–112. doi:10.1521/ijct.2010.3.2.97

Gilbert, P., Catarino, F., Duarte, C., Matos, M., Kolts, R., Stubbs, J., Basran, J. (2017). The development of compassionate engagement and action scales for self and others. *Journal of Compassionate Health Care*, *4*, 4. https://doi.org/10.1186/s40639-017-0033-3

Gilbert, P. & Choden. (2015). *Mindful compassion*. Robinson.

Gilbert, P. & Leahy, R. L. (2007). *The therapeutic relationship in the cognitive behavioral psychotherapies*. Routledge.

Gilbert, P., McEwan, K., Matos, M., & Rivis, A. (2010). Fears of compassion: Development of three self-report measures. *Psychology and Psychotherapy*. doi:10.1348/147608310X526511

Gilbert, P. & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy, 13*(6), 353.

Good, G. E., Khairallah, T., & Mintz, L. B. (2009). Wellness and impairment: Moving beyond noble us and troubled them. *Clinical Psychology: Science and Practice, 16*(1), 21–23. doi: 10.1111/j.1468-2850.2009.01139.x

Goodrich, J. (2012). Supporting hospital staff to provide compassionate care: Do Schwartz Center Rounds work in English hospitals? *Journal of the Royal Society of Medicine, 105*(3), 117–122.

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Psychopathology and Behavioral Assessment, 26*(1), 41–54.

Greenberger, D., Padesky, C. A., & Beck, A. T. (2015). *Mind over mood: Change how you feel by changing the way you think*. Guilford Publications.

Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare staff wellbeing, burnout, and patient safety: A systematic review. *PLoS ONE, 11*(7), 1–12. doi:10.1371/journal.pone.0159015

Hannigan, B., Edwards, D., & Burnard, P. (2004). Stress and stress management in clinical psychology: Findings from a systematic review. *Journal of Mental Health, 13*(3), 235–245. doi:10.1080/09638230410001700871

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. Guilford Press.

Haslam, D. (2015). "More than kindness". *Journal of Compassionate Health Care, 2*, 6. https://doi.org/10.1186/s40639-015-0015-2

Health and Care Professionals Council (2016) *Standards of conduct, performance and ethics.* Retrieved from http://www.hcpc-uk.org.uk/

Hill, R., Ryan, P., Hardy, P., Anczewska, M., Kurek, A., Dawson, I., … Rokku, I. (2006). Situational levels of burnout among staff in six European inpatient and community mental health teams. *The Journal of Mental Health Training, Education and Practice, 1*(1), 12–21.

Hojat, M., Mangione, S., Nasca, T. J., Cohen, M. J., Gonnella, J. S., Erdmann, J. B., Magee, M. (2001). The Jefferson Scale of Physician Empathy: Development and preliminary psychometric data. *Educational and Psychological Measurement, 61*(2), 349–365.

Howitt, D. & Cramer, D. (2014). *Introduction to SPSS in psychology* (6th edition). Pearson.

Institute of Quality and Efficiency in Healthcare (2016) *What is Burnout?*
Retrieved from https://www.ncbi.nlm.nih.gov/pubmedhealth

Jamieson, S. (2004). Likert scales: how to (ab)use them. *Medical Education, 38*(12), 1217–1218.

Joffe, H., & Yardley, L. (2004). Content and thematic analysis. In: *Research Methods for Clinical and Health Psychology* (pp. 56–68). Los Angeles, CA: SAGE.

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher, 33*(7), 14–26.

Johnson, S., Osborn, D. P., Araya, R., Wearn, E., Paul, M., Stafford, M., Lloyd-Evans, B. (2012). Morale in the English mental health workforce: Questionnaire survey. *The British Journal of Psychiatry, 201*(3), 239–246.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice, 10*(2), 144–156.

Kennerley, H., Mueller, M., & Fennell, M. (2010). Looking after yourself. In: *Oxford Guide to Surviving as a CBT Therapist* (p. 57).

Knapp, T. R. (1990). Treating ordinal scales as interval scales: An attempt to resolve the controversy. *Nursing Research, 39*(2), 121–123.

Kottler, J. A. (2011). *The therapist's workbook: Self-assessment, self-care, and self-improvement exercises for mental health professionals* (2nd edition). Hoboken, NJ: John Wiley & Sons.

Kuhn, T. S. (1996). *The Structure of Scientific Revolutions* (3rd edition). Chicago, IL: University of Chicago Press.

Kulik, L. (2006). Burnout among volunteers in the social services: The impact of gender and employment status. *Journal of Community Psychology, 34*(5), 541–561.

Kyeong, L. W. (2013). Self-compassion as a moderator of the relationship between academic burn-out and psychological health in Korean cyber university students. *Personality and Individual Differences, 54*(8), 899–902. doi:10.1016/j.paid.2013.01.001

Leary, M. R., Tate, E. B., Adams, C. E., Batts Allen, A., & Hancock, J. (2007). Self-compassion and reactions to unpleasant self-relevant events: The

implications of treating oneself kindly. *Journal of Personality and Social Psychology, 92*(5), 887.

Lee, J., Lim, N., Yang, E., & Lee, S. M. (2011). Antecedents and consequences of three dimensions of burnout in psychotherapists: A meta-analysis. *Professional Psychology: Research and Practice, 42*(3), 252–258. doi:10.1037/a0023319

Linley, P. A. & Joseph, S. (2007). Therapy work and therapists' positive and negative well–being. *Journal of Social and Clinical Psychology, 26*(3), 385–403. doi:10.1521/jscp.2007.26.3.385

Lown, B. A. & Manning, C. F. (2010). The Schwartz Center Rounds: Evaluation of an interdisciplinary approach to enhancing patient-centered communication, teamwork, and provider support. *Academic Medicine: Journal of the Association of American Medical Colleges, 85*(6), 1073–1081. doi:10.1097/ACM.0b013e3181dbf741

Maben, J. (2014). How compassion can be eroded in the NHS. *Journal of Holistic Healthcare, 11*(3), 12–16.

MacBeth, A. & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review, 32*(6), 545–552. doi:10.1016/j.cpr.2012.06.003

Malinowski, A. J. (2014). *Self-care for the mental health practitioner: The theory, research, and practice of preventing and addressing the occupational hazards of the profession.* London: Jessica Kingsley Publishers.

Mancini, A. D., Moser, L. L., Whitley, R., McHugo, G. J., Bond, G. R., Finnerty, M. T., & Burns, B. J. (2009). Assertive community treatment: facilitators and barriers to implementation in routine mental health settings. *Psychiatric Services (Washington, D.C.), 60*(2), 189–195. https://doi.org/10.1176/ps.2009.60.2.189

Marks, D. F. & Yardley, L. (2004). *Research methods for clinical and health psychology.* SAGE.

Maslach, C. (1982). *Burnout, the cost of caring.* Prentice-Hall.

Maslach, C. & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior, 2*(2), 99–113. doi:10.1002/job.4030020205

Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *Maslach Burnout Inventory Manual*. Consulting Psychologists Press.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology, 52*(1), 397–422.

Mathieu, F. (2011). *The compassion fatigue workbook: Creative tools for transforming compassion fatigue and vicarious traumatization*. Routledge.

Meltzer, H., Griffiths, C., Brock, A., Rooney, C., & Jenkins, R. (2008). Patterns of suicide by occupation in England and Wales: 2001–2005. *The British Journal of Psychiatry, 193*(1), 73–76.

Mills, J., & Chapman, M. (2016). Compassion and self-compassion in medicine: Self-care for the caregiver. Retrieved from researchgate.net.

Mills, J., Wand, T., & Fraser, J. A. (2015). On self-compassion and self-care in nursing: Selfish or essential for compassionate care? *International Journal of Nursing Studies, 52*(4), 791–793. doi:10.1016/j.ijnurstu.2014.10.009

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research*, *39*(5), 341–352.

Neff, K. D. (2003a). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity, 2*(2), 85–101. doi:10.1080/15298860309032

Neff, K. D. (2003b). The development and validation of a scale to measure self-compassion. *Self and Identity, 2*(3), 223–250. doi:10.1080/15298860309027

Neff, K. D. (2015). The Self-Compassion Scale is a valid and theoretically coherent measure of self-compassion. *Mindfulness, 7*(1), 264–274. doi:10.1007/s12671-015-0479-3

Neff, K. D. & Dahm, K. A. (2014). Self-compassion: What it is, what it does, and how it relates to mindfulness. In: *Mindfulness and Self-Regulation*. New York, NY: Springer.

Neff, K. D. & Germer, C. K. (2013). A pilot study and randomized controlled trial of the mindful self-compassion program. *Journal of Clinical Psychology, 69*(1), 28–44.

Neff, K. D., & Pommier, E. (2013). The relationship between self-compassion and other-focused concern among college undergraduates, community adults, and practicing meditators. *Self and Identity, 12*(2), 160–176. doi:10.1080/15298868.2011.649546

Neff, K. D., & Pommier, E. (in press) *Validation of the Compassion for Others Scale*. Retrieved from http://self-compassion.org/self-compassion-scales-for-researchers/

Negash, S., & Sahin, S. (2011). Compassion Fatigue in Marriage and Family Therapy: Implications for Therapists and Clients. *Journal of Marital and Family Therapy, 37*(1), 1–13. https://doi.org/10.1111/j.1752-0606.2009.00147.x

Nelson, T., Johnson, S., & Bebbington, P. (2009). Satisfaction and burnout among staff of crisis resolution, assertive outreach and community mental health teams: A multicentre cross sectional survey. *Social Psychiatry and Psychiatric Epidemiology, 44*(7), 541–549. doi:10.1007/s00127-008-0480-4

Newsome, S., Waldo, M., & Gruszka, C. (2012). Mindfulness group work: Preventing stress and increasing self-compassion among helping professionals in training. *The Journal for Specialists in Group Work, 37*(4), 297–311. doi:10.1080/01933922.2012.690832

NHS Careers (2016). *Psychological Therapies.* Retrieved from https://www.healthcareers.nhs.uk/explore-roles

NHS Choices. (2013). *The benefits of talking therapy – Stress, anxiety and depression – NHS Choices*. Retrieved from http://www.nhs.uk/Conditions/stress-anxiety-depression/Pages/benefits-of-talking-therapy.aspx

NHS Choices. (2015). *Psychotherapy – NHS Choices*. Retrieved from http://www.nhs.uk/Conditions/Psychotherapy/Pages/Introduction.aspx

NHS England (2014). *Building and Strengthening Leadership: Leading with Compassion.* Retrieved from https://www.england.nhs.uk/wp-content/uploads/2014/12/london-nursing-accessible.pdf

Norcross, J. C. & Guy, J. D. (2007). *Leaving it at the office: A guide to psychotherapist self-care*. New York, NY: Guilford Press.

Norman, G. (2010). Likert scales, levels of measurement and the "laws" of statistics. *Advances in Health Sciences Education*, *15*(5), 625–632.

Olson, K., Kemper, K. J., & Mahan, J. D. (2015). What factors promote resilience and protect against burnout in first-year pediatric and medicine-pediatric residents? *Journal of Evidence-Based Complementary & Alternative Medicine, 20*(3), 192–198. doi:10.1177/2156587214568894

Onyett, T. P. & Matt Mui, S. (1997). Job satisfaction and burnout among members of community mental health teams. *Journal of Mental Health, 6*(1), 55–66. doi:10.1080/09638239719049

Oxford Dictionaries Online (2016) *Burnout.* Retrieved from https://en.oxforddictionaries.com/definition/burnout

Pakenham, K. I. & Stafford-Brown, J. (2012). Stress in clinical psychology trainees: Current research status and future directions. *Australian Psychologist, 47*(3), 147–155.

Pallant, J. (2016). *SPSS survival manual* (6th edition). Maidenhead: Open University Press.

Papadopoulos, I., & Ali, S. (2015). Measuring compassion in nurses and other healthcare professionals: An integrative review. *Nurse Education in Practice.*

Poghosyan, L., Aiken, L. H., & Sloane, D. M. (2009). Factor structure of the Maslach burnout inventory: An analysis of data from large scale cross-sectional surveys of nurses from eight countries. *International Journal of Nursing Studies*, *46*(7), 894–902.

Pommier, E. A. (2011). The compassion scale. Dissertation Abstracts International Section A: Humanities and Social Sciences, 72, 1174.

Proctor, R. W., & Capaldi, E. J. (2008). *Why Science Matters: Understanding the Methods of Psychological Research.* John Wiley & Sons.

Prosser, D., Johnson, S., Kuipers, E., Szmukler, G., Bebbington, P., & Thornicroft, G. (1996). Mental health, 'burnout' and job satisfaction among hospital and community-based mental health staff. *The British Journal of Psychiatry, 169*(3), 334–337.

Raab, K. (2014). Mindfulness, self-compassion, and empathy among health care professionals: A review of the literature. *Journal of Health Care Chaplaincy, 20*(3), 95–108. doi:10.1080/08854726.2014.913876

Rao, A., Bhutani, G. Dosanjh, N., Clarke, J., Hacker Hughes, J., Easton, S., Van Laar, D., & Cohen-Tovée, E. (2016). Resetting the Balance: Psychological Wellbeing and Resilience.

Reader, T. W. & Gillespie, A. (2013). Patient neglect in healthcare institutions: A systematic review and conceptual model. *BMC Health Services Research, 13*, 156. doi:10.1186/1472-6963-13-156

Richards, K., Campenni, C., & Muse-Burke, J. (2010). Self-care and well-being in mental health professionals: The mediating effects of self-awareness and mindfulness. *Journal of Mental Health Counseling, 32*(3), 247–264.

Rimes, K. A., Wingrove, J., & web-support@bath.ac.uk. (2011). Pilot study of Mindfulness-Based Cognitive Therapy for trainee clinical psychologists. *Behavioural and Cognitive Psychotherapy, 39*(2), 235–241.

Ringenbach, R. T. (2009). *A comparison between counselors who practice meditation and those who do not on compassion fatigue, compassion satisfaction, burnout and self-compassion* (Doctoral dissertation).

Roth, A. & Fonagy, P. (2006). *What works for whom?: A critical review of psychotherapy research*. Guilford Press.

Rupert, P. A., Miller, A. O., & Dorociak, K. E. (2015). Preventing burnout: What does the research tell us? *Professional Psychology: Research and Practice, 46*(3), 168–174. doi: 10.1037/a0039297

Russell, T. (2014). Body in mind? The need for an integrative approach to compassion in the NHS. *Journal of Holistic Healthcare, 11*(1), 7–11.

Rutter, M. (1985). Resilience in the face of adversity. Protective factors and resistance to psychiatric disorder. *The British Journal of Psychiatry, 147*(6), 598–611. https://doi.org/10.1192/bjp.147.6.598

Saakvitne, K. W. & Pearlman, L. A. (1996). *Transforming the pain: A workbook on vicarious traumatization*. W.W. Norton.

Schaufeli, W. B., Martinez, I. M., Pinto, A. M., Salanova, M., & Bakker, A. B. (2002). Burnout and engagement in university students: A cross-national study. *Journal of Cross-Cultural Psychology, 33*(5), 464–481.

Schaufeli, W. B., & Van Dierendonck, D. (1995). A Cautionary Note about the Cross-National and Clinical Validity of Cut-off Points for the Maslach Burnout Inventory. *Psychological Reports, 76*(3_suppl), 1083–1090. https://doi.org/10.2466/pr0.1995.76.3c.1083

Shapiro, S. L., Astin, J. A., Bishop, S. R., & Cordova, M. (2005). Mindfulness-based stress reduction for health care professionals: Results from a randomized trial. *International Journal of Stress Management, 12*(2), 164–176. doi:10.1037/1072-5245.12.2.164

Skovholt, T. M. & Trotter-Mathison, M. J. (2011). *The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals* (2nd edition). Cambridge, MA: Routledge.

Smith, P. L. & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? *Clinical Psychology: Science and Practice, 16*(1), 1–15. doi:10.1111/j.1468-2850.2009.01137.x

Spandler, H. & Stickley, T. (2011). No hope without compassion: The importance of compassion in recovery-focused mental health services. *Journal of Mental Health, 20*(6), 555–566. doi:10.3109/09638237.2011.583949

Stafford-Brown, J., & Pakenham, K. I. (2012). The effectiveness of an ACT informed intervention for managing stress and improving therapist qualities in clinical psychology trainees. *Journal of Clinical Psychology, 68*(6), 592–513. doi:10.1002/jclp.21844

Stamm, B. H. (2010). *The concise ProQOL manual*. Pocatello, ID: ProQOL.

Stevanovic, P. & Rupert, P. A. (2004). Career-sustaining behaviors, satisfactions, and stresses of professional psychologists. *Psychotherapy: Theory, Research, Practice, Training, 41*(3), 301.

Tabachnick, B. G. & Fidell, L. S. (2013). *Using multivariate statistics* (6th edition). Harlow: Pearson.

Teater, M. & Ludgate, J. (2014). *Overcoming compassion fatigue: A practical resilience workbook*. PESI Publishing & Media.

Tillett, R. (2003). The patient within—Psychopathology in the helping professions. *Advances in Psychiatric Treatment, 9*(4), 272–279.

Turpin, G., & Coleman, G. (2010). Clinical psychology and diversity: Progress and continuing challenges. *Psychology Learning & Teaching*, *9*(2), 17–27.

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences, 15*(3), 398–405. doi:10.1111/nhs.12048

Van Laar, D., Edwards, J. A., & Easton, S. (2007). The Work-Related Quality of Life scale for healthcare workers. *Journal of Advanced Nursing, 60*(3), 325–333.

Vivino, B. L., Thompson, B. J., Hill, C. E., & Ladany, N. (2009). Compassion in psychotherapy: The perspective of therapists nominated as compassionate. *Psychotherapy Research, 19*(2), 157–171. doi:10.1080/10503300802430681

Walsh, S., & Cormack, M. (1994). 'Do as we say but not as we do': Organizational, professional and personal barriers to the receipt of support at work. *Clinical Psychology & Psychotherapy, 1*(2), 101–110. doi:10.1002/cpp.5640010207

Weiss, L. (2004). *Therapist's guide to self-care.* Routledge.

Welford, M. (2012). *The compassionate mind approach to building self-confidence.* London: Robinson.

Willig, C. (2013). *Introducing qualitative research in psychology.* McGraw-Hill Education (UK).

Wise, E. H., Hersh, M. A., & Gibson, C. M. (2012). Ethics, self-care and well-being for psychologists: Reenvisioning the stress-distress continuum. *Professional Psychology: Research and Practice, 43*(5), 487–494. doi:10.1037/a0029446

APPENDICES

Appendix A. Survey (Including Consent Form and Full Information)

COMPASSION, BURNOUT AND SELF-CARE IN NHS STAFF DELIVERING PSYCHOLOGICAL INTERVENTIONS

WELCOME

The aim of this study is to explore **compassion for self and others, burnout and self-care** in NHS staff delivering psychological interventions.

The overall aim of the research is to draw together different, yet converging, areas of theory and empirical research to investigate areas which have been theoretically linked, yet not empirically investigated to date. This topic is highly relevant due to the current NHS drive to improve both compassionate care and staff wellbeing.

The survey consists of **tick-box questions** and should take approximately **10-15 minutes** to complete.

Contact

For general enquiries about the research, please contact me (the researcher) via email: **Lisa Jayne Walker** (Trainee Clinical Psychologist) School of Psychology, University of East London, Water Lane, London E15 4LZ. Email: **u1138201@uel.ac.uk**

If you have any concerns regarding the conduct of the research in which you are being asked to participate, please contact: Catherine Fieulleteau, Research Integrity and Ethics Manager, Graduate School, University of East London, Docklands Campus, London E16 2RD (Tel: 020 8223 6683, Email: researchethics@uel.ac.uk)

Confidentiality

Responses are anonymous and confidential. No identifying data is collected. A secure online survey tool (LimeSurvey) is used. Data is stored using password-protected files and computers in accordance with national policy and legislation (The Data Protection Act, 1998) and BPS ethics guidelines for Internet-mediated research (BPS, 2013). Data is stored securely for up to five years in accordance with research publication guidelines (BPS, 2013).

Remuneration

As a thank you for completing the survey, you will have the option of entering a <u>prize draw to win one of five £20 Amazon vouchers by emailing the address given at the end of the survey</u>. This is entirely separate from survey data to ensure confidentiality and anonymity.

Benefits of involvement in this study include; contributing to an under-researched (yet seemingly important) topic, and increased awareness of self-care. Risks of involvement are unlikely. However, some participants may find certain questions trigger awareness of difficulties they may be experiencing. If this is the case you are encouraged to seek supervision and/or advice from staff support services.

Disclaimer

Your participation in this study is entirely voluntary. You are free to withdraw at any time during the survey without disadvantage to yourself, and without any obligation to give a reason. As data is anonymous, it is not possible to identify and withdraw data after it is submitted.

CONSENT TO PARTICIPATE IN THE STUDY:

COMPASSION, BURNOUT AND SELF-CARE IN NHS STAFF DELIVERING PSYCHOLOGICAL INTERVENTIONS

Terms and Conditions:

I have read and understood the information regarding the study: COMPASSION, BURNOUT AND SELF-CARE IN NHS STAFF DELIVERING PSYCHOLOGICAL INTERVENTIONS. The nature and purposes of the research, and my involvement, have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information.

I understand that my survey data is anonymous and confidential. Only the researchers involved in the study will have access to the data. I give my consent for the information obtained from this study to be used in relevant research publications.

Please choose **only one** of the following:

○ **I have read the terms and conditions stated above. I hearby freely and fully consent to participate in the study.**

Are you currently in TRAINING for your JOB ROLE? (e.g. as a trainee clinical psychologist, trainee PWP, etc.)

Please choose only one of the following:

○ Yes

○ No

Which term best describes your CURRENT JOB ROLE? (Or the job role you are currently training for?)

Please choose only one of the following:

○ Clinical Psychologist

○ Counselling Psychologist

○ Psychotherapist

○ Family Therapist

○ CBT Therapist

○ High Intensity Therapist

○ Counsellor

○ Psychological Wellbeing Practitioner

○ Graduate Mental Health Worker

○ Assistant Psychologist

○ Other - please give details in comment box

Make a comment on your choice here:

How many HOURS do you work in the NHS PER WEEK?

Please choose only one of the following:

○ Full-time

○ Part-time

○ Training contract

○ Other - please add space in comment box

Make a comment on your choice here:

ABOUT YOUR JOB...

How you view your job and the clients you work with...

Below are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about *your* job. If you have *never* had this feeling, tick the 'never' box to right of the statement. If you have had this feeling, indicate *how often* you feel it by ticking the box that best describes how frequently you feel that way.

Please choose the appropriate response for each item**:**

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel emotionally drained from my work.	○	○	○	○	○	○	○
I feel used up at the end of the workday.	○	○	○	○	○	○	○
I feel fatigued when I get up in the morning and have to face another day on the job.	○	○	○	○	○	○	○
I can easily understand how my clients feel about things.	○	○	○	○	○	○	○
I feel I treat some clients as if they were impersonal objects.	○	○	○	○	○	○	○
Working with people all day is really a strain for me.	○	○	○	○	○	○	○
I deal very effectively with the problems of my clients.	○	○	○	○	○	○	○
I feel burned out from my work.	○	○	○	○	○	○	○

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel I'm positively influencing other people's lives through my work.	○	○	○	○	○	○	○
I've become more callous towards people since I took this job.	○	○	○	○	○	○	○
I worry that this job is hardening me emotionally.	○	○	○	○	○	○	○
I feel very energetic.	○	○	○	○	○	○	○
I feel frustrated by my job.	○	○	○	○	○	○	○
I feel I'm working too hard on my job.	○	○	○	○	○	○	○
I don't really care what happens to some clients.	○	○	○	○	○	○	○
Working with people directly puts too much stress on me.	○	○	○	○	○	○	○
I can easily create a relaxed atmosphere with my clients.	○	○	○	○	○	○	○
I feel exhilarated after working closely with my clients.	○	○	○	○	○	○	○
I have accomplished many worthwhile things in this job.	○	○	○	○	○	○	○
I feel like I'm at the end of my tether.	○	○	○	○	○	○	○

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
In my work, I deal with emotional problems very calmly.	◯	◯	◯	◯	◯	◯	◯
I feel recipients blame me for some of their problems.	◯	◯	◯	◯	◯	◯	◯

SELF-CARE

Thinking about your life in general, BOTH AT AND OUTSIDE OF WORK**, please list any activities, practices, behaviours, etc. you do for self-care:**

Please write your answer here:

```

```

Please rate your agreement with the following statement: **'I am SATISFIED with my CURRENT level of SELF-CARE'**

Please choose only one of the following:

○ Strongly Disagree

○ Disagree

○ Neutral

○ Agree

○ Strongly Agree

SELF-COMPASSION

How do you typically act towards YOURSELF in difficult times (both at and outside of work)?

Please read each statement carefully before answering. To the right of each item, indicate how often you behave in the stated manner, using the scale provided. Please choose the appropriate response for each item:

	1 - Almost never	2	3	4	5 - Almost always
I'm disapproving and judgemental about my own flaws and inadequacies.	O	O	O	O	O
When I'm feeling down I tend to obsess and fixate on everything that's wrong.	O	O	O	O	O
When things are going badly for me, I see the difficulties as part of life that everyone goes through.	O	O	O	O	O
When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.	O	O	O	O	O
I try to be loving towards myself when I'm feeling emotional pain.	O	O	O	O	O
When I fail at something important	O	O	O	O	O

	1 - Almost never	2	3	4	5 - Almost always
to me I become consumed by feelings of inadequacy.					
When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.	○	○	○	○	○
When times are really difficult, I tend to be tough on myself.	○	○	○	○	○
When something upsets me I try to keep my emotions in balance.	○	○	○	○	○
When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.	○	○	○	○	○
I'm intolerant and impatient towards those aspects of my personality I don't like.	○	○	○	○	○
When I'm going through a very hard time, I give myself the caring and tenderness I need.	○	○	○	○	○

125

	1 - Almost never	2	3	4	5 - Almost always
When I'm feeling down, I tend to feel like most other people are probably happier than I am.	○	○	○	○	○
When something painful happens I try to take a balanced view of the situation.	○	○	○	○	○
I try to see my failings as part of the human condition.	○	○	○	○	○
When I see aspects of myself that I don't like, I get down on myself.	○	○	○	○	○
When I fail at something important to me I try to keep things in perspective.	○	○	○	○	○
When I'm really struggling, I tend to feel like other people must be having an easier time of it.	○	○	○	○	○
I'm kind to myself when I'm experiencing suffering.	○	○	○	○	○
When something upsets me I get carried away with my feelings.	○	○	○	○	○

	1 - Almost never	2	3	4	5 - Almost always
I can be a bit cold-hearted towards myself when I'm experiencing suffering.	○	○	○	○	○
When I'm feeling down I try to approach my feelings with curiosity and openness.	○	○	○	○	○
I'm tolerant of my own flaws and inadequacies.	○	○	○	○	○
When something painful happens I tend to blow the incident out of proportion.	○	○	○	○	○
When I fail at something that's important to me, I tend to feel alone in my failure.	○	○	○	○	○
I try to be understanding and patient towards the aspects of my personality I don't like.	○	○	○	○	○

Source: Neff, K. D. (2003). Development and validation of a scale to measure self-compassion. Self and Identity, 2, 223-250. Freely available from: http://self-compassion.org/self-compassion-scales-for-researchers/

COMPASSION FOR OTHERS

How do you typically act towards OTHERS (both at and outside of work)?

Please read each statement carefully before answering. To the right of each item, indicate how often you behave in the stated manner, using the scale provided. Please choose the appropriate response for each item:

	1 - Almost never	2	3	4	5 - Almost always
When people cry in front of me, I often don't feel anything at all.	○	○	○	○	○
Sometimes when people talk about their problems, I feel like I don't care.	○	○	○	○	○
I don't feel emotionally connected to people in pain.	○	○	○	○	○
I pay careful attention when other people talk to me.	○	○	○	○	○
I feel detached from others when they tell me their tales of woe.	○	○	○	○	○
If I see someone going through a difficult time, I try to be caring toward that person.	○	○	○	○	○
I often tune out when people tell me about their troubles.	○	○	○	○	○

	1 - Almost never	2	3	4	5 - Almost always
I like to be there for others in times of difficulty.	○	○	○	○	○
I notice when people are upset, even if they don't say anything.	○	○	○	○	○
When I see someone feeling down, I feel like I can't relate to them.	○	○	○	○	○
Everyone feels down sometimes, it is part of being human.	○	○	○	○	○
Sometimes I am cold to others when they are down and out.	○	○	○	○	○
I tend to listen patiently when people tell me their problems.	○	○	○	○	○
I don't concern myself with other people's problems.	○	○	○	○	○
It's important to recognize that all people have weaknesses and no one's perfect.	○	○	○	○	○
My heart goes out to people who are unhappy.	○	○	○	○	○
Despite my differences with others, I know that everyone feels pain just like me.	○	○	○	○	○

	1 - Almost never	2	3	4	5 - Almost always
When others are feeling troubled, I usually let someone else attend to them.	◯	◯	◯	◯	◯
I don't think much about the concerns of others.	◯	◯	◯	◯	◯
Suffering is just a part of the common human experience.	◯	◯	◯	◯	◯
When people tell me about their problems, I try to keep a balanced perspective on the situation.	◯	◯	◯	◯	◯
I can't really connect with other people when they're suffering.	◯	◯	◯	◯	◯
I try to avoid people who are experiencing a lot of pain.	◯	◯	◯	◯	◯
When others feel sadness, I try to comfort them.	◯	◯	◯	◯	◯

ABOUT YOU...

Age:

Please choose only one of the following:

- ○ Under 25

- ○ 26-35

- ○ 36-45

- ○ 46-55

- ○ 56-65

- ○ Over 65

- ○ Decline to answer

Gender:

Please choose only one of the following:

- ○ Male

- ○ Female

- ○ Other - please add details in comment box

- ○ Decline to answer

Make a comment on your choice here:

Ethnicity:

Please choose only one of the following:

○ White / White British / White Other

○ Mixed / Multiple Ethnic Groups

○ Asian / Asian British

○ Black / African / Caribbean / Black British

○ Other ethnic group - please add information to comments box

○ Decline to answer

Make a comment on your choice here:

SUBMIT

THANK YOU FOR COMPLETING THIS SURVEY

Please confirm your consent below to submit your data:

Please choose only one of the following:

○ **Please check this box to confirm you give consent for your anonymous responses to be used in this study.**

Please add any further comments or clarifications about the survey or your responses in the box below:

```

```

PRIZE DRAW

As a thank you for your time, you have the option of entering a **prize draw** to win one of **five £20 Amazon vouchers** by **emailing lisajaynewalkerpsychology@gmail.com** with the **subject 'prize draw'**. This ensures emails are entirely separate from completed surveys to ensure confidentiality and anonymity.

Appendix B. Ethical Approval Form

5   ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: Katy Berg   **ASSESSOR:** Ho Chung Law

STUDENT: Lisa Jayne Walker   **DATE (sent to assessor):** 03/07/2014

Proposed research topic: **COMPASSION, BURNOUT AND SELF-CARE IN NHS STAFF DELIVERING PSYCHOLOGICAL INTERVENTIONS**

Course: Professional Doctorate in Clinical Psychology

1. Will free and informed consent of participants be obtained?   YES
2. If there is any deception is it justified?   N/A
3. Will information obtained remain confidential?   YES
4. Will participants be made aware of their right to withdraw at any time? YES
5. Will participants be adequately debriefed?   YES
6. If this study involves observation does it respect participants' privacy? N/A
7. If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically?   N/A
8. Is procedure that might cause distress to participants ethical?   N/A
9. If there are inducements to take part in the project is this ethical?   YES
10. If there are any other ethical issues involved, are they a problem?   N/A

APPROVED

YES		

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: *HCL* Date: 03 July 2014

6 RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

SUPERVISOR: Katy Berg   **ASSESSOR:** Ho Chung Law

STUDENT: Lisa Jayne Walker   **DATE (sent to assessor):** 03/07/2014

Proposed research topic: **SELF-CARE, SELF-COMPASSION AND BURNOUT IN NHS STAFF DELIVERING PSYCHOLOGICAL INTERVENTIONS**

Course: Professional Doctorate in Clinical Psychology

Would the proposed project expose the <u>researcher</u> to any of the following kinds of hazard?

1	Emotional	NO
2.	Physical	NO
3.	Other	NO

(e.g. health & safety issues)

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as: HIGH / MED / LOW

APPROVED

YES		

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: *HCL* Date: 03 July 2014

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
University of
East London

www.uel.ac.uk

School of Psychology

Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966   fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk   web: www.uel.ac.uk/psychology

INVESTOR IN PEOPLE

CUSTOMER SERVICE EXCELLENCE
UK
The Government Standard

The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853

Appendix C. Invitation Email (Including Full Information Sheet Attached)

Dear colleague,

Are you currently delivering psychological interventions in the NHS as a <u>trainee OR qualified</u>: clinical psychologist, counselling psychologist, psychotherapist, family therapist, CBT therapist, HI therapist, counsellor, PWP, GMHW or assistant psychologist?

I am aware of how busy you are likely to be, but I would be very grateful it if you could spare around **10-15 minutes** of your time to **complete the following secure online survey** as part of the study:

> **COMPASSION, BURNOUT AND SELF-CARE IN NHS STAFF DELIVERING PSYCHOLOGICAL INTERVENTIONS**
>
> **http://surveys.uelconnect.org.uk/index.php/973574/lang-en**

Responses are anonymous and confidential. As a thank you for your time, you have the option of entering a **prize draw** to win one of **five £20 Amazon vouchers.**

I would be grateful if you could **please forward this email to any colleagues** who may be interested in taking part in the study.

Further details of the study are given in the information sheet attached and at the start of the survey. If you would like further information, please contact me via email: **Lisa Jayne Walker (Trainee Clinical Psychologist, University of East London) u1138201@uel.ac.uk**

Thank you for your time.

COMPASSION, BURNOUT AND SELF-CARE IN NHS STAFF DELIVERING PSYCHOLOGICAL INTERVENTIONS

INFORMATION SHEET

Student researcher: Lisa Jayne Walker Email: **U1138201@uel.ac.uk**

Professional Doctorate in Clinical Psychology, University of East London.

Director of Studies: Dr. Katy Berg Email: k.l.berg@uel.ac.uk

School of Psychology, University of East London. Tel: 020 8223 4409

The aim of the study is to explore compassion for self and others, burnout and self-care in over 100 staff, across the full range of roles delivering psychological interventions in the NHS. Roles include **trainee OR qualified: clinical psychologists, counselling psychologists, psychotherapists, family therapists, CBT therapists, HI therapists, counsellors, PWPs, GMHWs and assistant psychologists.** The overall aim of the research is to draw together different, yet converging, areas of theory and empirical research to investigate areas which have been theoretically linked, yet not empirically investigated to date. This topic is highly relevant due to the current NHS drive to improve both compassionate care and staff wellbeing.

Participants are recruited via email through researcher contacts and/or training courses and asked to **please forward this information to any colleagues who may be interested in taking part in the study**. Participants are asked to complete a secure online **survey**, taking approximately **10-15 minutes** to complete.

http://surveys.uelconnect.org.uk/index.php/973574/lang-en

Confidentiality

Responses are anonymous and confidential. No identifying data is collected. A secure online survey tool is used. Data is stored using password-protected files and computers in accordance with national policy and legislation (The Data Protection Act, 1998) and BPS ethics guidelines for Internet-mediated research (BPS, 2013). Data is stored securely for up to five years in accordance with research publication guidelines (BPS, 2013).

Remuneration

As an appreciation for completing the survey, you will have the option of entering a prize draw to win one of **five £20 Amazon vouchers** by emailing an address at the end of the survey. This is entirely separate from completed surveys to ensure confidentiality and anonymity. Benefits of involvement in this study include contributing to an under-researched topic, and increasing awareness of self-care. Risks of involvement are unlikely. However, if you find certain questions trigger awareness of any difficulties you may be experiencing, you are encouraged to seek supervision and/or advice from staff support services.

Disclaimer

Your participation in this study is entirely voluntary, and you are free to withdraw at any time during the research by exiting the survey. Should you choose to withdraw from the research you may do so without disadvantage to yourself, and without any obligation to give a reason. As data is anonymous, it is not possible to identify and withdraw data after it is submitted.

Research Integrity

This study has been approved by the UEL ethics committee. If you have any concerns regarding the conduct of the research in which you are being asked to participate, please contact: Catherine Fieulleteau, Research Integrity and Ethics Manager. Tel: 020 8223 6683, Email: researchethics@uel.ac.uk.

Appendix D. Self-Care Activities – Raw Data

The participant number (anonymous) is indicated on the left. Participant response to the question: **'Thinking about your life in general, BOTH AT AND OUTSIDE OF WORK, please list any activities, practices, behaviours, etc. you do for self-care'** is taken directly as written by the participant and is shown to the right of the participant number.

11	gym, food, friends, massage, beauty treatments, time with animals, supervision, time off, holidays, peer support
12	running, spending time with family and friends, cooking and baking, walking, watching light-hearted TV, speaking with colleagues, reading magazines and novels
13	exercise, time with friends/partner, mindfulness, meditation, leaving the office on time early nights, cooking, individual supervision, peer supervision
14	exercise, yoga, spending time with family and friends, holidays, TV, eating well, nights out
15	leaving on time, not being perfectionistic so allowing myself to attempt things and do a "good enough" job completing them, feeling okay about making mistakes. cycling instead of getting public transport. running around parks. eating well. getting emotional support from friends and family. taking a lunch break. getting emotional support from my staff team, and my supervisor. looking after my physical health.
17	mindfulness meditation including loving kindness practices, informal mindful activities, expressing how I feel with friends, relaxing activities with family, walking in the park, yoga, having a cup of tea.
18	taking a proper break at lunch, turning off work email, taking holidays
19	making sure I take lunch breaks, going to the gym, eating well, having days off, seeing friends/family, cooking, watching tv
26	yoga, gym, mindfulness
27	going out with friends, gardening, gym, massage, taking annual leave at regular intervals, not working too late, stroking the cats
29	sleep, listen to music, walk, exercise, spend time with partner, spend time with friends, alcohol, cooking, taking a bath, reading, being in the sun, don't work evenings or weekends
30	walk the dog, spend time with my family, cycling, going for a nice coffee, walking at work
33	at work - taking breaks when needs (where possible), taking regular annual (even if just a long weekend every couple of months), using supervision to discuss any concerns
	outside work - spending time with family and friends, running with a running club and

alone, spending time away from home (breaks to the country)

both work and home life - practicing mindfulness and compassion to myself and others.

34   yoga, meditation, regular breaks, consulting with colleagues, supervision

exercise, spending time with family and loved ones, tv and cinema, eating well, spending time in nature, regular sleep, eating out, taking short breaks from work (e.g.

35   10 minutes coffee breaks with colleagues, holidays, peer supervision.

compassionate mind practices, gardening, walking, talking to friends, pacing my work, working part-time

36

enter into therapy when I feel the need for this support. keep a personal journal in respect of my counselling work and maintain a personal diary in regard to my own life. member of a local fitness club - exercise, activity and relaxation which are essential components of the art of self-care. enjoy moments of solitude - find this can help to replenish my energy levels and is also very therapeutic. enjoy music - especially sounds of nature (the ocean in particular). love to meet up with friends and to have a laugh - humour and silly, harmless fun is a very important part of self-care. have also begun to take myself less seriously, which is, perhaps, one of my special ingredients of self-care. also believe self-care is a journey, a process and not an achievement. do not believe that self-care will ever be total or final or complete - it's an ongoing process

39   of discovery.

socialise, eat nice food, play with son, create art, meditate, holidays, cuddle, bake,

40   breathe, joke about things, walk the dog, avoid housework,

playing music, talking to friends and family, trying to eat healthily, trying to get enough sleep each day, mindfulness practices, compassion practices, care of body (e.g. using moisturiser)

41   taking breaks (at work), going for a walk

time with friends and partner, talking to colleagues, supervision, mindfulness compassionate mind exercise, exercise, leisure activities - reading, watching television, going out

44

being with/talking to close family and friends. reading. knitting and crafts. going out for coffee or meals. watching films. going for long walks in nature. holidays and short breaks. meditation/mindfulness/retreats. having a laugh! long baths with lovely oils/bath bombs/candles. stroking my much-loved cat. caring for my children and

51   granddaughter. keeping my environment clean and tidy.

find that it helps to be able to step out of the counsellor mind set both in social situations and to a degree at work with colleagues, particularly in the office between sessions, where humour creates a lightness that counters the frequent gloom of my

52   client work. enjoy a wide range of DIY activities; also do gardening, swimming, walking

and I love 'pushing the boat' out with friends, opening a few bottles of wine and having some good old fashioned fun!

55	walking, DIY, seeing friends and family

very poor at self-care. need to take this on board. see friends and family, enjoy

56	colouring and sorting my house chores.

supervision, physical exercise, socialising with friends/family, downtime e.g.

57	reading/music, holidays.

supervision/ debrief, informal chats with work colleagues, spending time with friends, going to the countryside, running/ exercise, eating well, yoga, having fun/winding down

58	after work

taking breaks; talking to colleagues for support; talking to friends; pursuing hobbies,

59	getting enough sleep.

exercise, healthy eating, talking to work colleagues, friends and family about how i am

60	feeling, and making sure i have time to myself.

supervision, informal peer supervision, yoga, talking to friends and family, sleeping and eating well, taking an hour for lunch on most days, making time to see friends/do

61	relaxing things, connecting to spirituality

rarely do these currently as am 3rd year writing up thesis!

but occasionally meditate, go for a walk, see friends though most activities are less

62	healthy e.g. shopping, drinking

walking, good food, meditation, yoga (not enough), music/dancing (not enough), humour with friends/colleagues, wearing clothes i `really like, reading, solitude, fresh

63	air.

sewing, exercise, reading , seeing friends / family, gardening

67	

watching trashy tv, spending time with my partner, family, and friends, mindfulness practice, reading novels, craft (particularly paper craft), supervision, informal discussions with colleagues, taking lunch breaks, eating healthily/eating enough ,

68	getting enough sleep, spending time outdoors, swimming
69	exercise, diet, mindfulness, reading, crafts, walking, socialising

talk to colleagues and supervisor, talk to friends, see friends and family, spend time

71	with own family, cooking, reading, exercising, playing/taking trips with own family

having time on my own to relax (read, watch tv). going for walks/being in nature. socialising with friends and family. massage. holidays/short breaks. taking sick days

73	when needed.

exercise, holidays, attending medical appointments and following advice, talking to other psychologists, spending time with family, mindfulness, self soothing, chill out

75	time by myself with rubbish tv.

cook healthy food, meet friends, supervision, holidays, walking, go out for meals /

76	drinks, watch tv

77	rest relaxation exercise sleep socialising
79	walking, lunch with friends, shopping, reading
80	time with close friends family and spouse. having things to look forwards to meals or drinks out. healthy eating and regular exercise of 2 to 3 hours a week. weekends or nights away. fortnightly massages for tense neck and shoulders! try to make time to do nothing much at all - although that's hard. oh and spa breaks!
81	running, mostly. and reading. sometimes, watching a film or so. drawing. also, have a reflective diary but use that somewhat infrequently. still, helps, though. meditation, rarely.
82	at work, it's usually just going for a brief walk, switching off. maybe reading, sometimes. depends.
	play with kids- interacting on their level stops me from overthinking and helps me to refocus on the important things, shopping!! on my own!! sit on the sofa watching tv with my husband drinking wine gin and tonic, meet my friend at work for lunch once a week. we work in different services so it's good to catch up and be aware of some of the stresses she has. drink tea at work
84	chat with work colleagues- i have a supportive office
	long baths, keeping in touch with friends, eating well, going for walks, making time for pleasurable activities, trying to sleep well, taking time off sick if I need to. taking breaks at work (about once a month!) and trying to keep my workload as manageable as possible.
85	exercise, reading books, socializing with friends / family, getting an early night after / before a heavy day, making sure i always take a lunch break , taking back toil / flexi hours accrued
87	spending time with friends; supervision/ talking things through; listening to music/podcasts; planning things to look forward to; resting; not doing anything work-related at home.
89	colouring by numbers, gardening, mindfulness, walking, breathing exercises, mindful moments, self-soothing, sharing my thoughts and feelings with others
90	family hugs, doing fun things as a family, taking my child to and from school, keeping on top of house work, spa, getting my hair and nails done. going to football matches. going out with friends for the night. days at home watching favourite tv shows. trying to read hard if stressed from work
91	being with my partner; my friends; wider family members. reading; walking; music; comedy; regular holidays. reminding myself that this a job not who i am. supervision; collegiate work relationships; recognition that the mental health system is mad. community and solidarity in the face of unsophisticated and nonsensical business ideas.

healthy eating, regular exercise, time with family/friends, sleeping well, enjoying hobbies, prioritise self-care i.e., ensuring I have enough of the above in my life, maintaining boundaries around working hours as much as possible, keeping track of extra hours worked and taking these back

prioritising supervision at work, maintaining my caseload/workload and ensuring that this is manageable

93

socialising, rest, baths, walks, eating well, (a little bit of mindfulness and yoga), being around people who are kind and interesting, music, being realistic about what I can do, no beating myself up for being less than perfect (had to work on this, but now comes pretty naturally)

94

96   use yoga a lot, but also use alcohol and food a great deal.

socialise, exercise, relaxation

97

am an active team member in the work environment and feel that it is imperative to contribute in this manner to maintain high morale and MDT working. reflective practice and supervision to aid clinical work.

outside of work I have a strong support system and look after my health and engage in a range of meaningful activities that make me feel good and enjoy.

100

CPD, further training, walking, running , yoga, being outside, holidays, socialising with friends and family

101

talking to friends and colleagues, supervision, work part time, have breaks from childcare

102

run, yoga, talk to friends/ family, using CBT techniques, plan fun activities, long baths, massage

103

Swimming, spending time in nature/on the beach, reading, socialising, drinking wine, watching theatre, watching tv

in work :supervision, getting a decent lunch, cups of tea, humour with colleagues, bring and share lunches with colleagues, meals put with colleagues, talking about difficult sessions

105

at work: supervision, peer supervision/discussion with colleagues, trying to make sure I have a lunch break. reflecting on what is going well as well as what i am struggling with, acknowledging that being a trainee can be hard.

outside of work: making sure I get enough sleep, book in time to see friends and family, try to eat well, make time for reading for fun, occasionally i'll exercise

107

109   listening to music. spending time with family.

110   relaxation, socialising with friends, interests outside work, physical exercise

yoga and meditation daily, 3 minute breathing spaces throughout day, take of shoes while in the office to feel the sensations of my feet on the ground, cycle 5 times a

113

week, spend time with a spiritual community, have good friends who are caring and nurturing.

115   reading, walking, running, baths, mindfulness, positive affirmations, pampering, family time, drinks with friends, good food, and escapism tv

116   walking, watching tv programmes, exercising, spending time with family/friends when i can.

119   socialising, exercising, speaking with partner & close friends, watching favourite tv shows, going to cinema. relaxation and breathing exercises. getting hair done. massage.

123   gardening, sewing, therapy.

124   in work: trying to get supervision and CPD, trying to leave on time, trying to get desk space so i can get some work done
outside work: doing things I enjoy, seeing friends, time to myself, variety, sleep, trying to stay well physically

128   listening to music, sleeping, eating (well and not well), socialising, talking, supervision, laugh, exercise, have fun

129   walking in mountains. wilderness camping. reading. meditation. mindfulness

130   work part time, have time to myself, paint my nails, go out with friends, spending time with husband and children eating well

132   de-stress treats:
-distractions (i.e. movies, social media)
- socialising - having dinner and drinks with friends
- exercise go to the gym
- eat healthily
- personal mindfulness activities.

135   exercise, mindfulness, reading, watching television, listening to music.

136   exercise, mindfulness, talking to friends and family (frequently), watching tv and movies, reading books, going out with people e.g. to dinner, drinks, cinema, walking, seeking support from colleagues e.g. supervision, informal chats, eating chocolate

137   getting a good diet of homemade food, going to bed at a reasonable time, taking time to do nothing, seeing friends/family, walking in the countryside, hobbies, venting my frustrations to a sympathetic listener, supervision, taking care of my health in a timely way

138   exercise, healthy eating, relaxation, 'me time', socialise, spend time with family/friends, doing things I enjoy, keeping my house nice and tidy, supporting others around me and looking out for myself as much as I can, trying not to feel guilty for taking some time out.

140   try to take my lunch break. don't beat myself up if i'm too tired to walk and get the bus.
socialising/talking to others. lighting incense/candles. watching Netflix.

cycling, running, seeing friends, reading, yoga, going to the gym.

141   talking with my colleagues about the problems that we all encounter at work.

taking time out to do things i like and things that relax me - mindful colouring, shopping

142   trips and walks.

spending time with wife/kids, cycling, seeing friends, running, watching tv, drinking

144   alcohol

personal care, take enough time to eat lunch/dinner, get enough sleep, gardening,

playing games, reading, meditation, going for a walk, talking to friends, watching tv-

145   shows/movies

146   mindfulness, healthy good food, gym, socialising

talking to friends and family, cooking, some sports, reading, watching some tv without

150   feeling guilty, going away outside London

try and get enough sleep, practice mindfulness, eat a varied and healthy diet, exercise

regularly (although probably not often enough!), spend time with others i care about

and attend any medical appointments as needed. at work I would take regular breaks

151   and seek supervision and support from the team.

keep to my contracted working hours, partake in exercise, see friends/family regularly,

have a good social life, make a lot of time for relaxation, supervision, peer supervision

- formally at work and with friends from training, reflect on what has affected me at

work and make sense of it, do cpd activities at work, spend time with work colleagues,

attend as many spaces for clinical discussion and other supervision as possible, take a

152   lunch break

yoga, Pilates, sleep, time with partner, time to self, baking , eating well

155

running, baking, reading, sleep, time with friends. at least half an hour for lunch with

156   colleagues, chats with colleagues.

exercise, eat well, treat myself, go out to nice places, socialise, spend time with those

who make me feel good, walks in the countryside, i aim for a balance between

reflection and self-awareness and mindlessness.

at work: clinical supervision, informal contact with other psychologists, allow time to

165   chat with others during the work day, vent.

having regular supervision, talking to peers, Pilates, meeting friends regularly, taking

166   regular annual leave

168   sports, seeing friends, drinking.

cuddling my cat, occasionally going for a coffee, moaning to certain colleagues,

169   annual leave and time out.

relaxation, meditation, mindfulness, make music, sleep, see friends, unwind with an

end-of-week pint. plan holidays, take a random day annual leave, plan nothing all

weekend

170

| 172 | meditation, yoga, socialising with friends and boyfriend, cinema, dance, holidays, running, cycling. |

| 173 | supervision and peer support at work. outside of work i make sure to spend quality time with my partner and friends and family. my cat also helps. i like to walk, cycle and dance- sometimes yoga. i like to go to gigs and art galleries and connect with other parts of life. |

| 174 | at work: supervision, going for coffee, getting some fresh air, chatting with colleagues. out of work: early nights, talking to friends, taking time for myself, sewing, baking. |

| 177 | talk to fellow trainees, use PPD group at university, see friends, go to theatre/music gigs |

| 179 | art, cooking, going to the gym/running, talking to friends, having a drink with friends, going dancing, listening to music, sleeping |

| 180 | I don't think that I do enough self-care strategies, but the ones that I do are as follows: (1) will take a day off if I am feeling absolutely exhausted (I consider this to be a sound reason for a 'sick' day, as is debilitating to me despite no physical pain etc.). (2) have a firm timetable of my working hours e.g. specific therapy slots and designated slots for other tasks e.g. admin, calling clients - will not reschedule therapy sessions within the same week as need this firm timetable to function properly at work. (3) don't check email throughout the day anymore, just at designated times in the day - i want to minimise disruptions and keep to my task list. (4) treat myself at the shops on payday and if i have had a difficult day or week at work - akin to a reward. (5) try to look my best for work, as this makes me feel that i matter and that my health is important too. |

| 181 | - almost always go home from work on time
- trying to leave time in between clients and leave time to write up notes - not seeing too many clients in a day
- see friends
- go out for dinner
- switch off and do no work in the evenings
- going to bed on time
- if had an emotional day - tell my partner that i need space that night and tell myself 'it's ok to feel this way' |

| 183 | Pilates, running, tennis, reading novels, book club, socialising, treating self to a treat e.g. nice coffee, chocolate etc., chatting with colleagues, seeking support from supervisor and colleagues |

| 184 | yoga, meditation, healthy eating, walking, drinking herbal tea, seeing friends, daily mindfulness practice, making homemade lunches, putting in boundaries at work and saying no to ensure work/life balance. |

meditation, walking the dog, walking in nature, listening to music, painting, photography, time with family and friends, eating well, try to go for a walk at lunchtime

185   when at work, occasionally stretch when sitting all day.

186   meditation, painting, reading fiction, walking pampering/using nice products

out of work: mindfulness meditation, yoga, cycling, swimming, gym, pay for private therapy, day trips into the countryside, seeing friends, book holidays

at work: mindfulness meditation, drink less coffee, try to avoid sugary foods and eat regular meals at work, try to eat away from my desk, walk around the local park after lunch

188

189   exercise, see friends, relax, eat healthy foods, get plenty of sleep

compassion focussed mediation (Buddhist orientation), mindfulness of breathing (Buddhist perspective), running, yoga, cycling, swimming, cognitive restructuring, talking to people

191   supervision, having a moan

193   talking to friends, reading novels, having a bath, hanging out with my family,

exercise 4-5 times a week.

socialise - 3 times a week.

cook meals - 5 times a week.

use supervision to discuss difficulties, use peer supervision daily,

194   use DNA's as down time if needed - go for a walk and get out the environment

maintain out of work friendships, sing in choir, regular holidays / get away from

198   workplace

supervision, writing (both about work and personal things), talk to friends, have a bath, go to bed early, seek support from colleagues, try not to work too many extra hours

200   and take time owing if i do

202   eating well, exercise, socialising, meditation

take time to cycle, walk, and think. i practice mindfulness, and do completely different

204   activities such as playing piano.

using supervision, talking to peers, attendance at team meetings. taking breaks regularly, eating lunch away from desk, stretching my legs regularly. reflect on how a patient or a day at work has made me feel. leave it at the office, not taking it home.

engaging in enjoyable activities and activities which give me a sense of satisfaction outside work. engaging with my family, reminding myself they are the most important

207   thing to me. exercising when can. eating well. seeing friends. engaging in hobbies.

making time to socialise with friends or partner. playing video games or watching films/tv series. reading. walking (e.g. always going for a walk at lunch during work). running/exercising (although not as much as I should) cooking (vegetarian!). intellectual debates/reading up on psychology related things. occasionally

208   mindfulness/appreciative type stuff.

massage, facials (pampering), mindfulness, reading, escapist movies or tv, planned fun with friends e.g. theatre or walks in nature, exercise (including relaxation and Pilates),someone to talk to whether friends or professionals - if an issue is bothering me that I feel I can't discuss with friends or need an expert in and cuddles with dogs or

212 partner

meditation, yoga, supervision, play with children, resting at home, eating good fresh vegetarian food, avoiding alcohol, having my own therapy, talking honestly with my

214 partner.

cook and eat well, stick to set starting, lunch and finishing times, spend time with

220 friends, go to gigs.

sleep, eat well, exercise, socialise with friends and family, read, spend time alone, watch tv, reflection

223

daily dog walking, meeting friends, special treats such as face mask or special shower gel, special foods, going out to restaurants, holidays, watching tv or films, sitting still and doing nothing, supervision at work, being boundaried with my time at work and leaving on time, only doing work in work time, taking sick leave if unwell, mindfulness, weekly yoga class, swimming, baking, sewing, browsing websites, offloading to friends

224 and family, keeping a sense of humour and perspective

speaking to my friends, watching tv shows, going to the cinema, having meals out, going to therapy, doing daily mindfulness practice, course reflective practice group, supervision, taking a longer lunch break away from office, taking holidays, talking to

225 course mates about current stresses, speaking with course staff about stresses

at home: running, gardening, Zumba, relaxing watching tv, spending time with loved ones regularly, building in free time. at work: pacing the work, balance of different clients on caseload, building in preparation time, spending time with colleagues who

228 are friends, banter.

230 talk to friends and colleagues, exercise, occasional pampering, holidays

taking breaks, talking to colleagues, debriefing, supervision, changing my hours, limiting my caseload, working flexibly, planning social activities, nice food, exercise,

231 hobbies, sleep, pampering

233 socialising, drinks

outside work: cooking/baking, swimming (/other exercise), spending time with my partner, calling my mum, watching tv programmes, quiet time just reading online/social media

in work: moan to a sympathetic colleague, take a short break- stretch my legs, get some water, look at pretty/distracting pictures on Instagram, create space in my diary in order for catch-up if overloaded with admin. leave work on time, where possible.

234 remind myself that no one is superman, no one is perfect.

235 early nights, lie-ins, dinners with friends, massage, good meals, quiet time with husband.

- sleep (7 hours a night at least)

- eat 3 meals a day plus snacking if hungry

- drink regularly (water for hydration, tea and coffee for comfort)

- have a half hour work related chat with my partner when we both come in from work to reflect on the day

- spend lots of time with my partner

- go to the gym 3 times a week

- go dancing

- spend time with family and friends (usually a trip to the cinema or meal mid week, then on the weekend have evening meals with my family and friends and go on nights out)

- phone call catch ups with my parents and sister

- watch my favourite tv programmes

- write to do lists at work to help me manage my workload

- have weekly supervision with my managers at work

- have catch ups with my colleagues throughout the day for breaks

- go for a walk at lunch if I feel too hot in the office

239 - allow myself to have evenings of doing nothing if I want to

going outside to appreciate nature, talking things through with trusted

240 friends/colleagues, making time to think things through/write things down

243 mindfulness, running, football, video games, eating nice meals, sleeping, reading.

yoga, breaks, snacks, reading literature, relaxing, right amount of light and air,

244 supervision

in work: use 'thinking together' from the ambit model to be supported by and support colleagues. have proper coffee with colleagues. try to take a proper lunch break when possible. practice mindfulness.

outside work: enjoy time with my family and friends; exercise - running, Pilates; mindful

246 activities; cooking.

247 socialise with friends and family, walking, reading, relaxation, mindfulness practice

reading (fantasy novels; never work related), playing games (ps4, ds), walking in the country side, running, gym (x1 per week), playing football (x2 per week), going for

248 meals, spending time with friends, relaxing with my fiancée, going to the pub.

work: taking regular breaks, social get together with peers, regular, good quality supervision and line management, saying no to extra work when I reach capacity

out of work: socialising with friends and family, holidays, walking, doing stuff for

249 myself, e.g. time for exercise, pampering etc.

	go to bed early (sometimes!), eat well, run (occasionally), never check work e-mails at home/weekend/off days, make music with friends, cook, spend time with my family, work in the garden, talk to husband about how i am, talk to work colleagues, supervisor, line manager about difficulties at work, try really hard to have a good
250	balance of work, chores, and nice things.
	gym, walking the dog, seeing friends, eating a nice meal, taking time to read, switching
252	off social media, listen to music and podcasts
	regular mindfulness practice, healthy eating, learning , reading poetry, being in nature,
253	letting in compliments from others, being with people i love
255	exercise, meditation, socialising
	mindfulness, walking, leaving the office for at least a walk round the block, time out for
256	myself, time with friends
	work - life balance (i work compressed hours - 4 days per week). clinical and management supervision . off load directly after client contact to a colleague if needed. not taking work home . flow activities (hobbies such as pottery / gardening / reading /
257	walking / birding . G&T
	spending time with my husband, family and friends. walking my dogs. cycling swimming and gym classes including yoga and mindfulness. socialising including; pub,
258	eating out, gigs and cinema.
261	see friends, look after my dog, watch tv, go to the gym
	spending time with family and friends, holidays, gardening, exercise, going out to eat
263	and drink, clothes shopping, reading, use of social media, cinema
	having a bath, cooking a meal, exercising, trying to take time out to have a lunch
264	break, reflection.
	being with friends and family, having time to watch tv or read, yoga, taking lunch
266	breaks, taking time to talk socially to colleagues
	activities: going to the gym, meeting my friends for a good chat or meal, reading a book, going on a holiday.
	practices & behaviours: making the time to have a good dinner almost every night,
268	taking a break for lunch, starting and ending the day on time as often as I can.
	mindful self-compassion meditation, cycle to work, drink tea/take breaks, eat well and regularly, maintain social contact during the day, spend time with my partner, talk about feelings/wishes/experiences, yoga, look after cats, see family and friends regularly, notice self-criticism and respond with self-kindness, limit how much I schedule into the day, allow time for notes, processing, thinking, reflecting, sleep in when i'm tired
269	
	taking breaks, talking to colleagues, mindfulness, swimming, spending time outside, bubble baths, reading, watching tv, spending time with friend, and family, stroking my
270	cat, baking, chocolate, wine, problem solving

271 personal: run, cook, go to art galleries, meet friends, travel, drink alcohol and museums (socially), read, take time out, walk, talk to friends
professional: engage in supervision, engage in personal therapy, talk to colleagues, go to lectures, go to reading groups/journal clubs

272 taking a lunch break; speaking to colleagues not about work; seeing friends and loved ones; doing yoga; sporting activities; using supervision in work; having a long bath!

273 switching off from work, managing caseload, being honest with managers/supervisors, taking holidays, enjoying life, seeing the bigger picture - balancing work and life, encouraging colleagues to look after themselves

276 regular physical exercise. talking to family, friends and colleagues. clinical supervision. negotiating workload with supervisors. engaging in leisure activities one day a week. reflective group.

277 gym, talking to friends, clinical supervision, breaks, holidays, relaxation and chill out time, self reflection/self practice

278 enjoying my food, going for long walks/bike rides, reading the newspaper, spending time with friends, appreciating small things, getting some sun, not sitting down too much.

280 musical theatre, time with friends, eating, sitting in silence, exercise

282 taking breaks, going to the chapel/ for a walk by the river etc. after a difficult client offloading to colleagues

283 wine!

284 run, drink (!), talk to friends/partner/colleagues, schedule in nice stuff, leave work before midnight even if I don't have the kids, practice the dark art of not giving a fuck if my paperwork isn't up to date

289 work out, climbing, reading, watch tv, relax, see friends, go out for meals, eat good food at home, sex, days out

290 mindfulness, watching television, reading, mindful colouring, walking my dog, sleeping, cooking, talking with family, seeing friends, drinks at the weekend

293 walking, running, holidays, listening to music

294 sports, wine, coffee in a cafe at lunchtime, meditation, a bath, an early night, switching off i front of the tv, talking to friends

296 running, mindfulness, socialising with friends, hiking, clean-eating

297 eating healthily; drinking lots of fluid; trying to get enough sleep; talking with friends, family and colleagues; taking breaks to relax; engaging in hobbies; exercising; taking time to reflect on my own thoughts/feelings

299 talk to family and friends use supervision, talk to peers. have fun do hobbies go for a run and swim, cook nice food, drink wine have a shout if things are really stressful or a cry. watch cheesy films or reread a favourite book. dance round house to music with my kids. attend to personal appearance, have a relaxing bath

300	time with family, yoga, exercise, walking, see friends, get enough sleep, eat well, set limits, be organised and prioritise, aim for good enough. have realistic expectations
302	meals. hairdressers. walks. spending time with my family
303	time for reflection in work. cups of tea. paint my nails. go to the gym. see my family. let others cook for me. cook a nice meal. let myself sleep in all day. have a duvet day. go for a walk. go and see the sea - it always helps.
310	clinical supervision, talking to colleagues, eating and sharing chocolate / cakes at work, talking to family and friends, walking, playing with my children, watching tv
311	exercise, trying to eat healthily, trying to have some time to reflect at some point
312	creative endeavours (knitting/ceramics), leaving my desk for lunch, making myself a real coffee in the morning. leaving the office before 6. socialise with friends. go for a walk. call up friends on the phone to talk.
313	seeing family and friends, swimming, watching films i love, gel nails, playing with my cats
315	running, speaking to colleagues about my emotions and difficult cases, supervision, walking, eating cake/biscuits, watching favourite to programme, listening to music, spending time with friends and family.
316	exercise, friends & family, mindfulness, time on my own, sharing problems
318	eat well, see friends, try to leave work on time and not work at weekend, shower after the day to unwind, mindfulness, self soothe acceptance and supervision, see friends, go out for dinner, tv etc.
322	mindfulness, yoga, play guitar, crochet, spend time with friends and family, read, take a lunch break
324	sing in two choirs, walk each day, attend physiotherapy at the moment and will return to Pilates soon, have gestalt psychotherapy, read sci-fi novels, play the piano, sit around doing nothing for a few moments...
325	speak to friends, spend time with friends and family, go out in the evenings/weekends and do something enjoyable, talk to colleagues at work when i feel distressed about my work, talk to supervisor, go on holiday, watch tv series (where i can take my mind off the real world for a bit), eat food, go for walks, Zumba etc.
326	eating well, exercising, not bringing work home, switching off (reading, films, time with family, camping etc.).
327	making time for my hobbies and seeing friends. talking to family on the phone. engaging in mindfulness occasionally (although it can be difficult to remember to do this). talking to my supervisor about things that i am finding about and which may be affecting my work.

329 mindfulness, exercise (running, weight-lifting, yoga), talking to my family and friends, watching shows/films, having nice hot showers, trying to prioritise getting at least 7 hours of sleep

330 relaxing watching tv, eating well, seeing friends and family, walking, reading, quiet time, using annual leave, talking to others about problems.

332 rest, see friends, sleep

334 time spent with spouse, friends, family. mindfulness/compassionate mind exercises, running and swimming, playing music and singing, listening to music

337 take 30 minutes for lunch, chat with colleagues, go gym, watch tv, heavy metal music, read novel

338 supervision, reading to feel more confident in work and reading for fun at home, exercise, sex/ romantic time with partner, cooking, eating chocolate, meeting friends, bath/ pampering, time alone

339 exercise, having baths, being kind to myself, seeing friends, having early nights, treating myself to something nice (even if that's just my favourite crisps)

342 yoga, running, personal therapy, supervision, reflective practice groups, time with friends - non work related and work related

343 socialise with friends, spend time with my children, play golf, meditate

344 playing sport, seeing friends and family, watching tv/films, walking, talking to colleagues, supervision, praying, eating nice food, regular holidays, leaving work on time.

345 mindfulness, seeing friends and family, going to the gum.

346 play piano, communication, relaxing with music, leisure activities, spending time with friends and family, balance and pace (comfortable) of workload

347 mountain biking, climbing, walking, making nice food, taking lunch breaks, spending time around people not talking about work

348 meditation, yoga, exercise, running, hiking, reading a book, spending time with friends and partner.

351 exercise, chatting with friends, going out for dinner, having a glass of wine/beer with friends, chatting with family, watching tv, sex

353 park my car 30 minutes walk from work, and walk in along the canal towpath; doctor and dentist appointments reasonably regularly; time on my own to recharge; birdwatching somewhere beautiful once a week; keep up with friends; learned not to take on extra commitments and responsibilities beyond my energy levels; enjoy my supper and glass of wine most evenings; continue to pursue CPD activities that interest me

354 at work: talk to trusted colleagues; line manager where appropriate; find quiet space to reflect; distract with other types of work

at home: time with family; activities such as knitting, gardening

357 meditation, compassionate exercises, physical exercises, time off from work, relationships away from work

361 gym, socialising, reading, watching television or films, listening to music, supervision sessions

362 speak to family and friends, exercise- running, part of a sports team, dancing, glass of wine, socialising, pedicures, occasional massage

363 running, cycling, family meals, days out with family/friends, film nights, massage, breaks away/holidays, catch up with friends (meals/walks), hair/beauty, gardening

364 socialise, exercise classes, listen to music and watch films, take lunch break away from desk and chat to colleagues over lunch

inside: attend supervision. spend a bit of time each day talking with colleagues about non-work "stuff".

outside: exercise regularly. wherever possible, go away for weekends/holidays with my family.

368 allow myself time in the evenings to relax and watch something interesting on television.

369 making time to spend with colleagues. maintaining contact with my friends. being thoughtful about my diet

374 see friends and family, exercise, watch box sets, read, cook, drink wine (not too much!)

-running

-discussing difficulties with supervisor/colleagues

-spending time with friends and family

377 -watching reality tv shows