“A mixed methods investigation of stress, compassion fatigue and satisfaction, governed by self-care strategies, for integrative Irish psychotherapists: This too shall pass.”

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Abstract

The aims of this study were threefold. Firstly, to compile strong quantitative and qualitative, baseline data, regarding demographics, measures for stress, compassion fatigue and compassion satisfaction and self-care strategies, for accredited integrative psychotherapists, on a national level. Secondly, to explore the relationship between these concepts, quantitatively and qualitatively and thirdly, to demonstrate the effectiveness of a mixed methodology approach to research. Seventy six participants (N=76), (Gender M/F = 15/61), (Age 35-44 = 10; 45-54 = 23; 55-64 = 37; 65-74 = 6) completed an on-line questionnaire and participants were purposively selected, on the basis of being accredited integrative Irish psychotherapists. Information was collected on, demographics, participation in several self-care strategies y/n, and on total consistent time, dedicated to self-care strategies per month. Participants were also rated on the perceived stress scale (PSS-10) (Cohen, Kamarck & Mermelstein, 1983) and on the professional quality of life scale (ProQol-V) (Stamm, 2010). The statistical analysis indicated that client hours per month significantly predicted stress scores, to a negative moderate amount and that academic qualifications significantly predicted burn out scores, to a positive minimal amount, no other significant predictive correlations were found. However, a profile plot indicated an inverse correlation between mean perceived stress scores and the amount of self-care strategies used, for therapists in private practice. No extreme scores were recorded for stress or burnout; some extreme scores were recorded for secondary traumatic stress (N=12) and compassion satisfaction (N=12). Qualitative analysis indicated the uniqueness of self-care strategies employed. Both methodologies highlighted areas of interest and concern including, access to Irish participant therapist populations, stigma/labelling associated with negative concepts and the importance of good supervision.
Introduction

“I have often asked myself whether I am not more heavily obligated to the hardest years of my life rather than to any others” (Nietzsche, 1895, P. 680)

Psychotherapy may be classified as one of the caring professions, in that the aim of the therapeutic alliance is the alleviation of symptoms, the identification of causation and the formulation of positive strategies and thought processes, to facilitate another human being to attempt to lead a fuller and more productive life. However, there may be a cost to the therapist, who is exposed to negative thoughts, traumas and pain on a regular basis, in the empathic exchange that is psychotherapy (Rogers, 1957; Verhaeghe, 2008; Yalom, 2011).

Previous research and literature in this area, is somewhat paradoxical and contradictory, as a result of overlapping concepts, inconsistent population sampling and other methodological limitations (Craig & Sprang, 2010; Kadambi & Ennis, 2004). Previous research has approached the subject through the concepts of stress, burnout, vicarious trauma, secondary traumatic stress, compassion fatigue, vicarious resilience and compassion satisfaction. Much of the earlier research has focused on the dangers and negative consequences for the therapist (Figley, 1995; McCann & Pearlman, 1990; Smith & Moss, 2009). Some of the later research has tended to focus on possible vicarious resilience or compassion satisfaction, which can result in positive psychological growth for the practicing psychotherapist (Craig & Sprang, 2010; Hernández, Engstrom & Gangsei, 2010). This research attempted to overcome problems associated with previous research, through
purposive sampling of participants \((N=76)\) (accredited members of I.A.H.I.P.), a focus on stress, compassion fatigue, compassion satisfaction and self-care strategies (as these were seen as the most appropriate concepts) and the use of the most validated scales for the measurement of these concepts. The perceived stress scale (PSS-10) (Cohen, Kamarck & Mermelstein, 1983), for measuring stress and the professional quality of life scale (ProQol-V) (Stamm, 2010), for measuring compassion fatigue and compassion satisfaction. Self-care was measured by consistent practice hours per month, from therapist’s self-reported figures.

However, as emphasised by the opening quotation from Nietzsche, the question remains unanswered, as to which of these two hypotheses is correct and what mediates the two distinctions. The importance of this research question cannot be over emphasised and is very relevant to integrative psychotherapy, as the knowledge of the impact of these factors not only informs the profession, but sets the basis for strategies, training and practice, that could aid in prevention and ensure a minimisation of negative effect (Bright & Harrison, 2013). From a review of the literature to date, on this subject, it would appear that there is a lacuna from an Irish, integrative/humanistic psychotherapy research perspective and that the majority of research is quantitative and not qualitatively based. Research conducted in psychotherapy in Ireland, would appear to be essentially qualitative. While both methods of research have their strengths and weaknesses, they complement each other and demonstrate overall, either research cohesion or disparity (Cooper, 2012; Howitt & Cramer, 2005). Good quantitative and qualitative research can be used in conjunction with one and other and offer a more all-encompassing analysis of data, which aids in the carrying out of research, in general. This may be seen as the meeting point between deductive
(moving from the general to the specific) and inductive (moving from the specific to the general) reasoning (Walton, 1999).

The aims of this research were threefold, to establish good, quantitative and qualitative baseline data, in relation to the concepts of perceived stress, compassion fatigue, compassion satisfaction and self-care strategies, from a national sample of integrative psychotherapists, in Ireland. Secondly, to explore, quantitatively and qualitatively, estimates for perceived stress levels, compassion fatigue and compassion satisfaction, for these integrative psychotherapists, and the effectiveness of combined and individual self-care strategies. Thirdly, to demonstrate the benefits of a mixed-methodology, as a means for research investigation. It was hoped that this data would go some way to establishing, whether integrative therapist participation in the therapeutic relationship, results in negative or positive consequences and what factors influence this, on a national level. Further, it was hoped that semi-structured interviews, of negatively impacted integrative therapists, would offer some idiographic insights, into possible causation and effective resilience based strategies, of self-care or self-maintenance.

This research, will now be approached, from the perspectives of a literature review, the methodology carried out, the data analysis, and a discussion section. The last section containing a discussion of results, limitations of this study, recommendations for future research and finally, a conclusion will be stated.
Section 1 - Literature Review

The above introduction highlights some of the problems within this area. The aim of this review will be to emphasise inconsistencies within the research and literature. Ordinarily, the first step in such an examination would be to establish baselines by recounting definitive, operational definitions for the concepts. However, due to a lack of construct consistency this is problematic, and one possible means of rectification of this problem will be offered. Firstly, a brief examination of the current research and literature on relative constructs/concepts will be given, then a critical examination of the literature will be offered, with an emphasis on validity (consistency of concept) and reliability (consistency of measurement) issues (Howitt & Cramer, 2005), and other methodological concerns. Current investigation methods will be briefly discussed and factors affecting psychotherapists, in this area, will be stated. How this study aims to overcome these limitations, will be addressed. Finally, a summary of findings will be given.

Stress:

Stress is more than a physiological response, there is also a psychological element and a social one involved in this transaction (biopsychosocial). According to Lazarus (1966), stress is a subjective experience and what counts as a stressor, differs for each individual. Therefore, the subjective nature of stress is a confounding variable that makes the identification of factors and individual stressors somewhat problematic. Many factors effect an individual’s susceptibility to stress, such as gender (Soares, Bridgeport, Prestridge, & Soares, 1992), self-esteem (O’Leary, 1992) and age of individual (Bartlett, 1998). Perhaps the most noted research carried out in this
area is in the area of social support. Generally this research has indicated that social support has a buffering effect against the negative aspects of stress (Greenwood, Muir, Packham, & Madley, 1996). In extreme cases stress is also linked with contributing to depression (Kanner, Coyne, Schaefer, & Lazarus, 1981), and hopelessness (a learned response from persistent failures to cope with stressful situations) which increases an individual’s risk for suicidal behaviour (Bonner & Rich, 1991).

Not only is stress perceived uniquely by different individuals, but the coping strategies used by individuals are also widely variant. Research has shown that individual characteristics affect the ability of individuals to cope with stressful situations (Kozak, Strelau, & Miles, 2005); similarly environmental factors, from a very young age, have been shown to effect an individual’s ability to regulate stress levels (Schore, 2003, 2014). Stress would appear to have its roots in the flight or fight response (Cannon, 1932), which has been added to by the inclusion of the freeze response (Levine, 1997; Rothschild, 2006; Schore, 2014). Psychological theories have perceived stress occurring as a result of cognitive assessment that resources (coping mechanisms) are unable to meet demands (stressors) (Lazarus & Folkman, 1984b). High self-efficacy and internal locus of control (the belief that one has the ability to influence the surrounding environment and change the situation) have also been linked to greater coping with stress (Petrosky & Birkimer, 1991). High self-esteem has also been shown to have a positive effect on coping with stress (Seeman, Berkman, Gulanski, Robbins, Greenspan, Charpentier, & Rowe, 1995). Therefore, we can see that stress is a biopsychosocial (biological, psychological and social) phenomena. More recent stress prevention research has focused on mind-body relaxation, through the application of physical exercise, meditation, mindfulness and breathing exercises (Fan, Tang & Posner, 2014; Werneburg,
Herman, Preston, Rausch, Warren, Olsen & Clark, 2011), these studies all involved a lowering of stress levels, as a result of practicing these techniques over a short period (four and twelve weeks, respectively) of time. Similarly, mind-body techniques have been demonstrated to have positive effects on the reduction of stress levels in counselling and therapist training programmes (Felton, Coates & Christopher, 2013; Schure, Christopher & Christopher, 2008). However, the practice, prevalence and impact of such strategies remains largely unexplored for current, established therapist populations.

**Burnout (BO):**

Burnout is generally considered to be influenced by work related variables; which makes it problematic for therapists/mental health professionals to engage with clients due to physical, mental and emotional barriers, as a result of organisational impediments and conditions (Maslach & Leiter, 2008; O’Connor & McQuaid, 2013). Research has indicated that symptomologies associated with this construct include emotional exhaustion, depersonalisation and a lack of personal development (feelings of work inefficacy) (Wetherell & Carter, 2014; Wu, Hu & Yang, 2013). However, how these factors interact with one and other and effect size, remains unclear. More recent research has indicated that the first two of these are more strongly related to burnout and the third is more of a personality variable (Hallberg, Johansson & Schaufeli, 2007; Purvana & Muros, 2010). Factors consistently associated with the antecedents of burnout include, increased workload, limited support (social and work related), role conflict and role ambiguity and personal characteristics of the individual (Maslach, Schaufelli & Leiter, 2001; Wilkerson & Bellini, 2006). Research has indicated that good supervision, mindfulness, relaxation training, peer networking and continuing professional development, are all factors aiding in burnout prevention (Hayes,
Burnout then, would appear to only be an applicable diagnosis if it occurs as a result of organisational stressors, rather than from the impact of the work itself (Schauben & Frazier, 1995). However, the compound impact of life stressors (Kendler, Kendler, Karkowski & Prescott, 1999) does not appear to be considered. Also, many of the symptomologies associated with this construct could just as easily occur in private practice, as in an organisational setting.

**Compassion fatigue (CF):**

The two terms, secondary traumatic stress (STS) and compassion fatigue, are used interchangeably by many (Figley, 1995; Sexton, 1999), and both have their roots in post-traumatic stress disorder (PTSD), an anxiety disorder from the ‘Diagnostic and Statistical Manual of Mental Disorders’ (DSM) (A.P.A., 1980, 1994, 2000, 2015). Stamm (2010) has indicated that secondary traumatic stress is one half of compassion fatigue (the other being burnout) and is related to carers treating individuals, who have suffered primary stress and trauma. According to Stamm (ibid) this results in the therapist being traumatised by the experiences of the client. However, surely there is more at play here, the counter-transference from the client will be one part, but the therapist’s transference and countertransference must also play into the equation (Freud, 1912). The effects associated with the construct are avoidance of trauma reminders, sleep difficulties, and intrusive images. However, it has also been argued that compassion fatigue was created primarily for mental health professionals (therapists, first responders, social workers), as a result of perceptions of labelling and stigma attached to the terms, secondary traumatic stress and burnout (Elwood, Matt, Lohr & Galovski, 2010; Figley, 1995).
Compassion satisfaction (CS):

According to Stamm (2010) compassion satisfaction occurs as a result of the therapist being able to do their work in an efficacious manner, to assist clients/colleagues, to facilitate a better quality of life for clients or to ameliorate suffering in the other. Increases in a therapist’s capabilities/efficacy, through training, have been demonstrated to increase compassion satisfaction and decrease compassion fatigue and burnout (Linley & Joseph, 2007; Sprang, Clark & Whitt-Woosley, 2007). Compassion satisfaction arises from feeling satisfied by one’s work and contribution to the welfare of others and is contingent on feelings of happiness, success and being able to make a difference in the lives of others. Therefore, the feeling of control is an important constituent, as indicated in the stress section (Petrosky & Birkimer, 1991). However, in order to qualify for compassion satisfaction, as opposed to fatigue or burnout, the therapist must have perceptions of self-efficacy as a result of their work, therefore, it would appear a positive effect on clients is required. This study seeks to examine these factors, within the population under examination.

Vicarious Trauma (VT):

This concept seeks to break down the individual components of self, both conscious and unconscious, that are affected by traumatic exposure and are postulated as mechanisms of change, both positive and negative (Saakvitne, Tennen & Affleck, 1998). The negative changes in the therapist can manifest themselves in depression, emotional numbing and/or flooding, cynicism, physical ailments, anxiety, suspiciousness, avoidance, sadness, personal vulnerability and intrusive thoughts and feelings (Pearlman & McIan, 1995; Saakvitne, 2002; Saakvitne & Pearlman, 1996; Saakvitne, Tennen & Affleck, 1998; Steed & Downing, 1998).
Other contributing factors associated with vicarious trauma are affect style (the more reactive the greater the risk), interpersonal coping style (work-life balance, boundaries) and personal circumstances (current stressors in the therapist’s life) (Cerney, 1995; O’Connor & McQuaid, 2013). Yet, often forgotten is the fact that the negative affect/effects are often transient and not chronic/cumulative over time. Some studies have emphasised the fact that large numbers (not better quantified) of therapists have experienced periods of distress, as a result of therapeutic engagement, but only for a short while (Chrestman, 1995; Steed & Downing, 1998). However, some researchers have argued that VT is only applicable to therapists dealing exclusively with clients who have experienced extreme traumatic stress (recently referred to as traumatologists) (Pearlman & McIan, 1995; Schauben & Fraizer, 1995). Kadambi and Ennis (2004) argue that this focus appears correct, given the necessary conditions to justify vicarious trauma and resilience (exposure to cruelty, graphic material and participation in trauma enactments) (Pearlman & Saakvitne, 1995a). However, what this would appear to be saying, is that VT is actually an extreme form of STS. Consistently, the quantitative studies that have been conducted on vicarious trauma/burnout have failed to identify high levels of symptomologies among participants (Arvay & Uhlemann, 1996; Baird & Jenkins, 2003; Kadambi & Truscott, 2003. This lack of verification has been attributed to methodological limitations and under reporting by participants (due to stigma, labelling) (Elwood, Matt, Lohr & Galovski, 2010; O’Connor & McQuaid, 2013), rather than a questioning of the construct itself (Kadambi & Ennis, 2004).

Interestingly, previous research has also indicated that perceived stress, burnout and secondary traumatic stress, are preventable, and transient conditions rather than fixed (Hayes,
2013; O’Connor & McQuaid, 2013). Many researchers have also indicated that compassion satisfaction and resilience are overlooked; that the majority of therapists cope well with the demands of their profession and even flourish, grow and expand as individuals, as a result of their work with clients (Goldberg, 2002, Hernández, Engstrom & Gangsei, 2010; Saakvitne, Tennen & Affleck, 1998; Steed & Downing, 1998). Given the above facts a focus on stress, compassion fatigue and compassion satisfaction, for the purposes of this study, appears correct.

One possible solution to this stigma/labelling problem, is a return to the beginning. While the uniqueness and population specialisation of the concepts (BO, VT and STS) is acknowledged. However, the problems with under reporting, due to stigma and labelling, hinders the investigation of them, and all of the above negative concepts have their roots in stress. Perhaps if these concepts, in total were to be investigated using a stress spectrum or continuum, similar to how autism is described in the DSM-V (APA, 2015), then the limits to research investigation would be minimised or reduced. Concepts, as above, could be viewed as the extreme ends of such a spectrum/continuum, as contributing to acute or chronic stress. However, a review of the above recommendation is seen as beyond the scope of this study.

Self-care

The above and other research has indicated that a number of factors effect the ability of psychotherapists to gain satisfaction from their work. These factors can impact negatively or positively in that, what protects from burnout or VT, also leaves the individual more open to satisfaction and resilience and vice versa. A lack in these areas is also viewed as leaving an
individual more susceptible to stress/trauma/burnout. These factors can broadly be sub-divided, into work-related and personal-related (O’Connor & McQuaid, 2013).

Work related:

Personal supervision (Linley & Joseph, 2007; O’Connor & McQuaid, 2013), Peer support and supervision (O’Connor & McQuaid, 2013; Thompson, 2003), Diverse caseload (Chrestman, 1995), Clear boundaries (Cerney, 1995; Neuman & Gamble, 1995), Clinical experience (Adams, Boscarino & Figley, 2006; Sheehy & Friedlander, 2009), Trauma history (Linley & Joseph, 2007; Saakvitne, 2002), workload (Pearlman, 1995; O’Connor & McQuaid, 2013), negative/positive work support (Saakvitne & Pearlman, 1996), ongoing training and education (Linley & Joseph, 2007; Follette, Polusay & Millbeck, 1994).

Personal-related:

However, perhaps it would be more useful, for psychotherapists, to focus on what is essential and what is preventative. With regard to all of the above, factors like a balanced client list, balanced lifestyle, boundaries, supervision, peer/social support can be seen as essential, while factors like mindfulness, personal therapy, meditation, breaks/holidays, physical exercise, and healthy lifestyle can be viewed as preventative. This is perhaps, where awareness (Figley, 2002; O’Connor & McQuaid, 2013) comes into play, in that therapists must be aware of their own process, their own traumas, triggers, resilience etc. Thus, therapists must adopt preventative strategies that will be uniquely suited to themselves. Consistent practice of strategies adopted, is the best defence for therapists against negative consequences (Derthick, Ivanovic & Swift, 2015).

Supervision, deserves a special mention, in that, while it is mandatory, it could also be viewed as an essential preventative factor. Supervision solely takes over the role provided by training programmes, a secure base (Bowlby, 1988). The purpose of supervision is twofold; to protect the interests of clients and to aid in the process and development of therapists. In the second of these, supervision is unique, in that it provides a platform for therapists to cultivate their own awareness, not only of their part in the therapeutic relationship, but for what is going on for them as human beings, in relationship. The role of good supervision, therefore, is seen as essential as a preventative measure against extreme negative factors. (Bernard & Goodyear, 2014; Falender & Shafranske, 2014)

Another factor affecting therapists, which is seen as being outside of the scope of the above factors, is the requirement for an acceptance and openness to the susceptibility of therapists,
to conditions like chronic stress, burnout and vicarious trauma. This requirement is seen as relating to self, peers, organisations, associations and psychotherapy, in general (O’Connor & McQuaid, 2013). Given the above complexity and diversity of self-care strategies, a single factor measuring individual involvement in self-care seems preferable. Consistent therapist hours, spent on self-care per month, represents such a factor.

**Construct validity:**

There is a wealth of literature and research, indicating that conceptual/construct validity is not the strongest aspect of this area of investigation (Kadambi & Ennis, 2004; Linley & Joseph, 2007; Lim, Yang & Min Lee, 2011). There is overlap between many of the constructs and also areas of distinction (Dunkley & Whelan, 2006; Stamm, 2010). For example, Figley (1995) uses the terms compassion fatigue and secondary traumatic stress interchangeably, and vicarious trauma would appear to be an extreme form of secondary traumatic stress. However, as explained above, Stamm (2010) indicates that secondary traumatic stress is one component of compassion fatigue. Accordingly, and to overcome such problems, a focus on stress, compassion fatigue and compassion satisfaction seem appropriate, stress is included as personal life stressors do not appear to be adequately represented, in the other concepts.

**Measurement and reliability:**

A reliability problem also arises in the quantitative measurement of these concepts, in that there is rarely consistency with the measurement instruments used. Instruments used have included the Maslach Burnout Inventory (MBI) (Maslach, Jackson and Leiter, 1996), The Traumatic Stress
Institute Belief Scale Revision L (TSI) (Pearlman, 1996) and The Professional Quality of Life Scale (ProQOL) (Stamm, 2010). These instruments have been revised on several occasions and the versions cited are not always the originals, so several versions have been used in studies, dependant on relevant timescales. There is also the matter of control for confounding variables; many studies are over reliant on the main measurement instrument, without taking into consideration confounding variables (Pearlman & McIan, 1995; Stamm, 2010). There is also the matter of what is considered to be a confounding variable, for instance clinical psychologists may not consider that personal therapy is relevant to the study. However, some good studies have been carried out in this area, one example being (Brockhouse, Msetfi, Cohen & Joseph, 2011). Brockhouse’s study sampled from a single trauma therapist population (N=118). Moderation analysis was carried out, with growth (similar to compassion satisfaction levels) as the outcome variable. This study controlled for gender, age, support, ethnicity, qualifications, training orientation, practice orientation, experience, personal therapy, supervision (frequency and orientation) and hours per week with clients. The results of this study indicated that personal therapy, age, social support, supervision, high empathy and client hours, all moderated a greater sense of growth and satisfaction, no other factors were seen as making significant contributions (ibid). It is posited that similar controls are essential in order to produce reliable results, as many of these controls have been demonstrated to influence the constructs under investigation (Linley & Joseph, 2007; Pearlman & Saakvitne, 1995b). Given the above, sampling from a single therapist population appears correct. Based on the previous selection of constructs, the selection of the following measurement scales is also deemed appropriate, the perceived stress scale (PSS-10) (Cohen, Kamarck & Mermelstein, 1983) and the professional quality of life scale (ProQol-V)
(Stamm, 2010), some demographics will also be collected, along with the main variables, for comparative purposes with previous research (ibid; Linley & Joseph, 2007).

A further reliability issue arises in connection with population sampling and its relevance to the general population. Some studies have focused on too narrow a population, such as Pearlman and McLean (1995), which was based on a sample of trauma specialists only, collected at a trauma specialist workshop, and is not therefore representative of mental health or psychotherapist populations generally. Other studies have focused on too diverse populations, including first scene responders (Firemen, police etc.), social workers and other mental health professionals. One example of this is Craig and Sprang’s (2010) study, which sampled 532 (N=532) clinical psychologists and social workers, but failed to control for personal or supervision therapy and other factors. In order to overcome this problem, the sample will be drawn from accredited integrative psychotherapists, in Ireland, all having similar training, orientation and accreditation standards.

**Research objectives**

**Hypotheses:**

H1 – There will be a significant predictive correlation, between perceived stress levels, for integrative therapists, on a national level, and self-care hours per month, personal therapy hours per month, academic qualifications, years accredited as therapists and client hours per month.
H2 - There will be a significant predictive correlation, between burnout score levels, for integrative therapists, on a national level, and self-care hours per month, personal therapy hours per month, academic qualifications, years accredited as therapists and client hours per month.

H3 - There will be a significant predictive correlation, between secondary traumatic stress score levels, for integrative therapists, on a national level, and self-care hours per month, personal therapy hours per month, academic qualifications, years accredited as therapists and client hours per month.

H4 - There will be a significant predictive correlation, between compassion satisfaction score levels, for integrative therapists, on a national level, and self-care hours per month, personal therapy hours per month, academic qualifications, years accredited as therapists and client hours per month.

Qualitative:

From a qualitative perspective the general aims of this study are, to explore the lived, idiographic relationship, of Irish integrative psychotherapists to stress, burnout, compassion fatigue and compassion satisfaction, moderated by self-care strategies. Further, to explore these relationships, in comparison to previous research and to identify areas of concern and to make recommendations for future research, in this area, going forward. Questions in the semi-structured interviews (appendix G), were set up, to minimise the stigma/labelling effect (ibid), attached to
negative concepts, to identify negatively and positively impacting moderators and to identify both current and past levels/triggers for negative impact, on the population under review.

From a co-operative perspective (quantitative and qualitative), to demonstrate how a mixed methodology, can identify areas of cohesion and disparity in research and how this can be an aid to strengthening research methods, specifically in this study, but also in general.

Summary:

The concepts of stress, burnout, compassion fatigue, compassion satisfaction, vicarious trauma and resilience have been briefly examined. Perception and impacts of stress differ individually. A number of factors were identified that impact stress directly; stress has its roots in the flight, fight and freeze responses. As well as stressors differing individually, so do coping strategies. Mind-body relaxation techniques have been shown to have a positive impact on stress levels. Burnout is considered to occur as a result of work variables, which seriously impacts on the health and ability of therapists to do their work. Compassion fatigue, is closely related to PTSD and may be divided into BO and STS and has serious negative consequences for therapists. STS is related to secondary trauma and results from exposure to primary stress and trauma, as in the therapeutic relationship. Compassion satisfaction occurs as a result of the internal positive feelings, which arise as a result of helping others. VT has its roots in secondary trauma and results in serious negative consequences for therapists. However, VT appears to only relate to therapists who are continually exposed to extreme forms of trauma. Stress, BO, VT, STS, are all seen as transient and treatable. These negative concepts are also associated with stigma/labelling, one possible way to
deal with this, is to investigate these concepts across a stress spectrum/continuum. Reliability and validity issues have also been identified with regard to previous research, and how this research seeks to overcome them has been stated. Several factors have also been seen to impact, both negatively and positively, on therapist’s wellbeing. These factors may be sub-divided into work and personal related, but perhaps a more appropriate sub-division would be essential and preventative. The objectives of this study have also been stated. As a result of the above factors, this research focused on stress, compassion fatigue, compassion satisfaction and self-care strategies. The methodology, related to this study, will next be stated.
Section 2 - Methodology Section

Research Design:

This study involves a mixed methods design, both quantitative and qualitative analysis. The quantitative analysis is a within groups, descriptive, cross-sectional and correlational study. One aim is to indicate whether there is any significant predictive relationship between therapist self-care hours per month, average personal therapy hours per month, academic qualifications, therapist years accredited and average client hours per month (combined or individually) and perceived stress scores, burnout scores, secondary traumatic stress scores and compassion satisfaction scores (individually). Qualitative data was analysed using interpretative phenomenological analysis (IPA), the purpose of this analysis was to gather rich, idiographic data, in a questioning mode and to enhance the overall understanding of this complex and many faceted subject matter. The quantitative and qualitative methodologies will now be stated and a design justification and ethical considerations sections will complete this chapter.
Quantitative

Electronic questionnaire:

An electronic questionnaire (Appendix A) was created on a web-site dedicated to survey data collection, SurveyMonkey (2014-15). This questionnaire consisted of a range of demographic questions, designed to elicit information on age, gender, relationship status, self-care strategies, self-care hours p.m., average client hours per month (p.m.), average personal therapy p.m., average personal supervision p.m., organisational or private practice, specialist or general practice, academic qualifications and willingness to participate in a one hour interview. Two pre-existing established questionnaires were also used, the ‘Perceived Stress Scale’ (Cohen, Kamarck & Marmelstein, 1983) (Appendix B), and the ‘Professional Quality of Life Scale’ (Stamm, 2010) (Appendix C). Electronic copies of these scales were obtained from Dublin Business School, the scales were then accurately transposed into the questionnaire.

The perceived stress scale (PSS-10): (Cohen, Kamarck & Marmelstein, 1983)

The PSS represents the most widely used psychological instrument for measuring the perception of stress. This scale consists of a 10 item self-reporting measure, of the degree to which situations in one’s life, are perceived as stressful. In particular the items used in this scale are designed to show the levels at which participants perceived their lives to be unpredictable, uncontrollable and overloading (Cohen, Kamarck & Marmelstein, 1983). All questions are scored on a five point Likert type scale of 0-4, from never to very often; four of the questions are negatively stress oriented and scoring is reversed for them i.e. 0=4 etc. This 10-item scale was held to have a high internal consistency, demonstrating a Cronbach’s alpha
coefficient of .78, \(N=2387\) (Cohen & Williamson, 1988). In the current study, the Cronbach alpha coefficient was .88, \(N=76\). Test-retest reliability demonstrated scores ranging from .85, after two days and .55 after six weeks (Cohen, Kamarck & Mermelstein, 1983). More recent research has confirmed both validity and reliability, internal and cross cultural consistency (Cohen & Janicki-Deverts, 2012; Lee, 2012; Ramirez & Hernandez, 2007). Scores range from 0-40, are non-diagnostic and there are no cut off scores, individuals are adjudged on their recorded stress levels, within the sample under consideration (Cohen et Al., 1983)

The professional quality of life scale (ProQOL-V): (Stamm, 2010)

The professional quality of life scale measures two aspects, the positive compassion satisfaction (CS), the satisfaction and positive feelings one gets from ones profession/job and the negative, compassion fatigue (CF). CF is broken down into two further parts. The first part concerns things such like exhaustion, frustration, anger and depression typical of burnout (BO). The second part, secondary traumatic stress (STS) is a negative feeling driven by fear and work-related trauma. The questionnaire is comprised of thirty questions, all questions are scored on a six point Likert type scale of 0-5, from never to very often, five of the questions are negatively scored, so scores must be reversed for them i.e. 0=5 etc. Questions are then allocated to specific predefined concepts i.e. BO = Q’s (1, 4, 8, 10, 15, 17, 19, 21, 26, 29), question scores are totalled and converted from raw scores to t scores. Based on the total, converted t score, an individual may then be scored as low (43 or less), average (around 50) or high (57 plus) in each of the three concepts, scores should be examined in conjunction with one and other, rather than on an individual concept basis i.e. the worst combination would be someone who scores high on BO and STS and low on CS. Stamm (2010) is very specific, that scores are not diagnostic or assessment based. This 30 item scale was held to have a high
internal consistency, demonstrating Cronbach alpha coefficients of .88 (N=1130), .75 (N=1135), .81 (N=1135), for CS, BO and STS, respectively (ibid). In the current study, the Cronbach alpha coefficients for CS, BO and STS were .88, .72 and .80 respectively, (N=72). Research has also indicated good cross-cultural consistency and good concurrent, convergent and discriminant validity, with some shared variance between the two scales burnout and secondary traumatic stress (34%) (r = .58; Co-σ = 34%; n = 1187) (ibid). However, Stamm (ibid) indicates that these are definitively different concepts, with STS addressing fear and anxiety, which BO does not.

Participants:

The sample for this study consists of seventy-six (N = 76), (Gender M/F = 15/61), (Age 35-44 = 10; 45-54 = 23; 55-64 = 37; 65-74 = 6), integrative psychotherapists in Ireland. Originally there were eighty-one, but five of these had to be removed as they were incomplete. The sample consists of accredited members of the “Irish Association of Humanistic and Integrative Psychotherapy” (I.A.H.I.P., 2015). In order to limit as many confounding variables as possible i.e. training, personal therapy, supervision etc., the use of an organisational framework (I.A.H.I.P., 2014) that considers these variables as prerequisites to membership, seemed appropriate. Exclusion criteria was therapists not yet accredited, as these are seen to carry stressors, not directly related to therapeutic practice.

Sample collection:

Purposive sampling (Coolican, 2007) was employed for this study and no participant limit was applied. Firstly, the “Irish Association of Humanistic and Integrative Psychotherapy” (I.A.H.I.P., 2015), agreed to place a request for participation in this study (Appendix D) on
their weekly classifieds section. The request was e-mailed to approximately six hundred people, some of whom are psychotherapists and some of whom are not (no better figures available). The advertisement contained an explanation on the nature and purpose of the research, the researcher, anonymity, right to withdraw, contact details of the researcher, and a request to accredited psychotherapists to participate. A direct web link to the questionnaire was also provided. It was hoped that this medium would yield a sample in excess of one hundred participants. However, despite waiting for three weeks, only ten participants responded. Accordingly, it was decided to issue a follow up e-mail to psychotherapy centres and individual psychotherapists and request participation (Appendix E), all e-mail addresses were accessed individually, via the public domain. A total of four hundred and eight e-mails were sent requesting participation. The main weakness, attached to this form of data collection, is that it is respondent dependant (Coolican, 2007), and a poor response would limit the representativeness of the data set to the population under examination.

Quantitative data analysis:

Raw data was imported from SurveyMonkey (ibid), to a home computer (Dell, XPS), in excel format. The data was then cleaned, excesses removed, this included the removal of five incomplete participants, this left data for 76 (N=76) participants. Interestingly, of the five incomplete participants, four stopped completing the survey at the exact same question, the first one related to self-care strategies. The “other” section of self-care strategies was analysed, only one consistent factor was identified, peer/social support. Accordingly, a separate variable was created based on this factor, all other data for this section was excluded. Total scores for stress, burnout, secondary traumatic stress and compassion satisfaction were calculated. The edited data was imported into SPSS and analysed using the statistical package for the social
Access to this statistical package was provided by Dublin Business School. A series of standard multiple regression analyses were carried out, to test the predictive value of several predictor variables, on single criterion variables. Predictor variables used were average self-care hours per month, average personal therapy hours per month, academic qualifications, therapist years accredited and average client hours per month. The last four predictor variables used were controls, to check for cohesion with established research. Criterion variables used were perceived stress scores, burnout scores, secondary traumatic stress scores and compassion satisfaction scores. Preliminary analyses was also carried out to ensure no violations of the assumptions of normality, linearity, multicollinearity and homoscedasticity. In accordance with the rules for sample size (Stephens, 1996, P. 72), fifteen subjects are required for each predictor variable. Further, an analysis of Mahalanobis distance values (Tabachnick & Fidell, 2007) identified one extreme outlier in the client hours per month variable (200), this figure seems unlikely, and is probably the result of participant input error i.e. 200 instead of 20. This extreme outlier was removed (entered as a missing value). An analysis was also run with this value reduced to the next closest score, no significant differences were recorded between these two analyses and therefore, the outcomes reported excluded this outlier. No other violations were detected.
Qualitative

**Interpretative Phenomenological Analysis (IPA):**

IPA’s roots lie in phenomenology and hermeneutics (Smith & Osborn, 2008), it is a research method whose goal is to understand the lived human experience (Langdridge, 2007). Phenomenology emphasizes “describing phenomena, in the broadest sense as whatever appears in the manner in which it appears, that is as it manifests itself to consciousness, to the experiencer.” (Moran, 2006, P. 4). Therefore, phenomenology is concerned with the real meaning of things. Hermeneutics is concerned with “the art of deciphering indirect meaning…..the interpretation of the multiple mediations of meaning through symbol, myth, dream, image, text, narrative and ideology.” (Kearney, 2001, P. 91), therefore hermeneutics is concerned with the interpretation of meaning. IPA makes use of and expands on these two philosophical areas of enquiry, in that it also emphasizes the dynamic role of the researcher, in all areas of the research (Smith, Flowers & Larkin, 2009).

The researcher is not only attempting to enter the interviewee’s world, but is attempting to interpret how they make sense of their world, in effect a double hermeneutic (Smith & Osborn, 2008). The researcher is constantly wondering what is going on, beyond the words. In many ways this form of analysis is well suited to psychotherapeutic research, as the interviewer and interviewee relationship mimics the therapeutic relationship. The interviewer is not trying to steer the interview to their own agenda, but allows the interviewee to unfold their world, seeking connection and an intersubjective experience of the interviewee’s world, much like the method of “evenly suspended attention” (Freud, 1912, P. 111). Researchers have indicated that this form of analysis provides intensive fine grained, idiographic (lived experience) analysis,
which prioritises the experiential world of the individual. Further, it provides contextualized and rich data, which can flesh out the more general data that can be uncovered with more prima facie thematic analysis (Kearney, 2001; Smith, Flower & Larkin, 2009).

Participants and sample selection:

Three accredited integrative therapists were selected to participate in IPA interviews, this figure is in keeping with current recommendations (Smith, Flower & Larkin, 2009; Smith & Osborn, 2008). Sampling was purposeful and not probability related (ibid). Interviewees were selected, based on their indication of willingness to participate and on those who scored highest in the burnout scale. Individuals selected scored fifteenth, twentieth and twenty-seventh highest respectively in burnout scores. The reason that higher scoring individuals were not selected, is that they had indicated they would not be willing to participate in an interview. The three interviewees were female. All three interviewees had experience of working in organisations.

Sample collection:

Prior to the interview (approximately one hour before), the interviewer attempted to bracket off (Moran, 2006) his own biases and agenda for the interviews. This is a phenomenological technique, performed in an attempt to truly enter, open-endedly into an objective search for meaning, this was accomplished through a twenty minute mindfulness meditation. Objectivity was envisaged as a state to be aimed for, as it is extremely unlikely that a state of pure objectivity could ever be a reality (Chalmers, 2004).
Prior to the recorded interviews, which lasted approximately fifty minutes, interviewees were each given two forms (Appendix F), an information form and a consent form. The information form covered background interviewer, what their research covered, what the interview entailed and how confidentiality would be respected. The consent form included, six yes/no tick boxes, which each interviewee had to tick and indicated the interviewees understanding of the information form, the right to withdraw, confidentiality, risk, audio recording of the interview and that they had been given a copy of both forms, interviewees were required to sign and date each form and this was witnessed by the interviewer. The purpose of the interview, the concepts under investigation and a brief history of the topic was also given, in verbal form.

Interviews took place in three different location types. The first took place in the living room of the private residence of the interviewee, the second in a room reserved for meetings in DBS, and the third in a private therapy room. Interestingly, the location set the tone for each of the interviews. The first interview was more collegial, with extracts from private and professional experiences. The second was more guarded to start, possibly as a result of a desk placed between interviewer and interviewee, though this did open up after a while, so perhaps the physical obstruction hindered connection at the start. The third interview was more boundaried i.e. the interviewer arrived ten minutes early and was asked to return at the agreed time, as the interviewee was not ready. This third interview was also more work-oriented, although this is not to say that it was any less authentic and open, only that a review of the data indicated less private life examples. In reality, it is hard to say whether the interviewee influenced the environment or the environment influenced the interviewee.
The interviews then began and interviewees were informed that recording was beginning. Interviews were conducted in a semi-structured format, in keeping with ideal recommendations (Smith, Flowers and Larkin, 2009; Smith & Osborn, 2008). A list of eleven questions (Appendix G) had been previously prepared and had been validated by thesis supervisors and peers. The interviewer attempted to give the interviewees as much leeway as possible, to stick to their own dialogue, in recounting their lived experiences. The interviewer attempted to keep introjections to a minimal, to introduce new questions only when previous ones were exhausted. However, occasionally due to the nature of connection and dialogue some discursive exchanges took place, though these were always grounded in the subject matter of the research. At the end of the interview, the interviewer informed each interviewee when the recording was ending. Following the termination of the recording, five to ten minutes was given to debrief; how they were currently feeling and an appreciation for their participation. Each interviewee was also asked whether they wanted to know their individual scores from the quantitative analysis and all three requested same Prior to disclosure each interviewee was informed that these scores were neither assessment nor diagnostic based and that the scores merely represented a snap-shot of themselves, at one particular moment in time. Only one interviewee scored a borderline high score for secondary traumatic stress, interestingly she also scored a similar score for compassion satisfaction, all other scores were average.

Approximately one hour after the interview, the interviewer sat down and wrote down his experience of the interview, including body awareness, unrecorded material, emotions and feelings, about the interview and the interviewee.
Data analysis:

Data was analysed using the recommended methods for IPA (Smith, Flowers, Larkin, 2009; Smith & Osborn, 2008). Data was collected using an Olympus vn-731pc digital recorder and each separate interview was transcribed into a Microsoft word document and printed off. Commencing with interview one, Fiona (pseudonym), the transcript was read and re-read several times (at least five). On the next reading of the document key words and themes were identified and written in the left and right hand margins of the document. The document was then manually divided into the eleven questions asked, by drawing a red line, across the page, separating them; each question was then divided into arbitrary parts by drawing a green line across the page, and each questions sub-divisions were then allocated a sequential letter i.e. 1(A), 1(B) etc. A written, manual list was then compiled of the themes/key words and their frequency and location within each document i.e. Awareness = 1(A); 2(D); 6(E); 10(D) etc. Each key word and theme that emerged from the document was then clustered into several groupings. Connections within groupings were then examined and some of the key words/themes were moved around into other groupings. A conscious and visualisation process was used to accomplish this, on a conscious level similarities were identified, for the visualisation piece it was imagined that a set of magnets was pulling the polarised, related pieces together. A review of these finalised groupings lead to the establishment of the superordinate and subordinate themes within the data. It is appreciated that this is difficult to imagine and so an example of this process is attached, for one interviewee, with original data excluded (Appendix H). The same process was then repeated for the second and third interviewees.
The transcripts were then converted from Microsoft word to excel and broken down into their separate questions and sub-divisions. The original list of frequencies of key words, sentences and vignettes were then examined with the most appropriate and representative examples identified. These examples were then located in the excel document, copied and converted back to Microsoft word with the proper coding attached; the examples were then grouped under the appropriate superordinate and subordinate themes. Each word document was constructed separately i.e. there were three interviewee documents, with the relevant quotes under each of the theme headings. Each theme was then examined separately by comparing and contrasting the experiences of each of the three interviewees; notes taken post interview were also examined to identify physical and emotional content or other matters pertaining to the interviews. Each theme was then written up based on the data and supported by vignettes, from the interviewees.
Justification for design:

There would not appear to be any doubt in the literature reviewed that stress, burnout, secondary traumatic stress and compassion satisfaction are complicated concepts and that their manifestations are a result of a multitude of inter-related factors. Accordingly, the use of a quantitative, standardised multiple regression analysis is seen as essential, in that it enables the analysis of the impact of many factors, on the concepts of stress, fatigue and satisfaction. The use of the target population is similarly seen as important, in that it eliminates confounding variables from the study i.e. training, personal therapy etc. The variables selected are considered appropriate to the hypotheses under investigation and the concepts being examined. The use of IPA is also seen as important, in that previous research has indicated, that there is an element of stigma and labelling attached to many of the negative concepts for therapist populations (Elwood, Matt, Lohr & Galovski, 2010; O’Connor & McQuaid, 2013). IPA is seen as being a possible solution to this problem, as it permits the interpreter to look beneath the surface of the themes, which will provide a richer source of information (Smith, Flowers & Larkin, 2009; Smith & Osborn, 2008).
Ethical Considerations:

Accredited, integrative, I.A.H.I.P. psychotherapists were invited to participate in this study. The aim and objectives of the study were outlined for those who participated in the questionnaire and the interviews. Participants were informed that their anonymity will be protected, in so far as is possible. Information (data) collected was stored in a password protected folder, which only the researcher has access to and will be deleted following a period of time (three months post submission). A number was allocated to each participant in the questionnaire, and all references to data thereafter was by way of the allocated numbers. Similarly, all participants in the interviews were awarded aliases and all references to them was by way of allocated pseudonym. All references to materials which could compromise the interviewees were disguised. All participants were informed that participation in the study is voluntary and that they have the right to withdraw before, during, or after participation. Consent forms were issued individually to interviewees (appendix F) and were inserted as a part of the invitation to participation in the electronic questionnaire (appendices D and E). After completing of the questionnaires, participants were invited to contact the researcher (e-mail address for the questionnaire and phone number for the interviewees) should they have any concerns. Given the psychotherapeutic backgrounds of the population being researched, it was not deemed necessary to provide information outlining effects and impact of stress, burnout or secondary traumatic stress. It was also felt the preceding scenario (contact details researcher) would cover any outliers. Following each interview, a five to ten minute debrief took place and any advice deemed necessary was given. No interviewee appeared adversely affected by either the content or process of the interviews.
Section 3 - Data Analysis

Quantitative

Descriptive statistics:

Gender

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>61</td>
<td>80</td>
</tr>
<tr>
<td>Female</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Totals</td>
<td>76</td>
<td>100</td>
</tr>
</tbody>
</table>

Table i: Descriptive statistics for gender distribution, indicating frequency and percentages.

Therapist place of employment

<table>
<thead>
<tr>
<th>Practice</th>
<th>Number of Participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>16</td>
<td>21</td>
</tr>
<tr>
<td>Own premises</td>
<td>17</td>
<td>22</td>
</tr>
<tr>
<td>Centre</td>
<td>22</td>
<td>29</td>
</tr>
<tr>
<td>Organisation</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Mixed</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Totals</td>
<td>76</td>
<td>100</td>
</tr>
</tbody>
</table>

Table ii: Descriptive statistics for therapist place of employment, indicating frequency and percentages.

Therapist employment in Public or Private Sector

<table>
<thead>
<tr>
<th>Sector of Employment</th>
<th>Number of Participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Private</td>
<td>64</td>
<td>84</td>
</tr>
<tr>
<td>Totals</td>
<td>76</td>
<td>100</td>
</tr>
</tbody>
</table>

Table iii: Descriptive statistics for private/public sector, indicating frequency and percentages.
Therapist in full-time/part-time employment

<table>
<thead>
<tr>
<th>Employment as therapist</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time</td>
<td>35</td>
<td>46</td>
</tr>
<tr>
<td>Part-time</td>
<td>41</td>
<td>54</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>76</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table iv: Descriptive statistics for full/part-time employment, indicating frequency and percentages.

Therapist Practice

<table>
<thead>
<tr>
<th>Type of practice</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>65</td>
<td>85</td>
</tr>
<tr>
<td>Specialised</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>76</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table v: Descriptive statistics for general/specialised practice, indicating frequency and percentages.

Meditation

<table>
<thead>
<tr>
<th>Practicing</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>38</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>38</td>
<td>50</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>76</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table vi: Descriptive statistics for meditation, indicating frequency and percentages.

Mindfulness

<table>
<thead>
<tr>
<th>Practicing</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>49</td>
<td>65</td>
</tr>
<tr>
<td>No</td>
<td>27</td>
<td>35</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>76</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table vii: Descriptive statistics for mindfulness, indicating frequency and percentages.

Breathing exercises

<table>
<thead>
<tr>
<th>Practicing</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>42</td>
<td>55</td>
</tr>
<tr>
<td>No</td>
<td>34</td>
<td>45</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>76</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table viii: Descriptive statistics for mindfulness, indicating frequency and percentages.
Physical exercise

<table>
<thead>
<tr>
<th>Practicing</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>56</td>
<td>74</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td>Totals</td>
<td>76</td>
<td>100</td>
</tr>
</tbody>
</table>

Table ix: Descriptive statistics for physical exercise, indicating frequency and percentages.

Social/Peer support

<table>
<thead>
<tr>
<th>Practicing</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>No</td>
<td>65</td>
<td>85</td>
</tr>
<tr>
<td>Totals</td>
<td>76</td>
<td>100</td>
</tr>
</tbody>
</table>

Table x: Descriptive statistics for social/peer support, indicating frequency and percentages.

Willingness to participate in interview

<table>
<thead>
<tr>
<th>Practicing</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>35</td>
<td>46</td>
</tr>
<tr>
<td>No</td>
<td>41</td>
<td>54</td>
</tr>
<tr>
<td>Totals</td>
<td>76</td>
<td>100</td>
</tr>
</tbody>
</table>

Table xi: Descriptive statistics for interview participation, indicating frequency and percentages.

Number of self-care strategies practiced

<table>
<thead>
<tr>
<th>Number strategies</th>
<th>Number of participants</th>
<th>Percentage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>One</td>
<td>17</td>
<td>22</td>
</tr>
<tr>
<td>Two</td>
<td>20</td>
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<td>Three</td>
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<td>Four</td>
<td>21</td>
<td>28</td>
</tr>
<tr>
<td>Five</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Totals</td>
<td>76</td>
<td>100</td>
</tr>
</tbody>
</table>

Table xii: Descriptive statistics for number of self-care strategies, indicating frequency and percentages.
An analysis of raw scores for all continuous variables was also carried out. This analysis indicated the following points of interest: for perceived stress, \((N = 76)\), range = 0 – 24 (mean = 12.29, \(SD = 5.34\)), no high values. However, eight participants (9%) scored under five, with one scoring zero. Four participants \((N = 4)\) who completed all other sections of the questionnaire did not complete the ProQol. No extreme scores were recorded for burnout, \((N = 72)\), range = 28 – 52 (mean = 36.75, \(SD = 6.23\)). Range of score for secondary traumatic stress \((N = 72)\), 36 – 67 (mean = 48.75, \(SD = 7.55\)), twelve participants (17%) scored above 57, indicating high \((12 \geq 57)\) levels (Stamm, 2010). Range of scores for compassion satisfaction \((N = 72)\), 35 – 61 (mean = 49.83, \(SD = 6.69\)), twelve participants (17%) scored above 57, indicating high levels \((12 \geq 57)\) (ibid). The individuals who scored high for secondary traumatic stress, were not all the same as those that scored high on compassion satisfaction. Range of scores for self-care hours per month \((N = 76)\), 0 – 60 (mean = 18.05, \(SD = 13.75\), 13
participants indicated under 5 hours (13 < 5), with one indicating 0. Range of scores for personal therapy hours per month (N = 76), 0 – 7 (mean = 1.53, SD = 1.61) twenty-seven participants (36%), indicated 0 hours per month.

**Inferential Statistics:**

This section will show the relevant parametric inferential statistical results, from a series of standardised multiple regression tests:

1. Multiple regression was used to test whether self-care strategies hours per month, personal therapy hours per month, academic qualification, years accredited and number of client hours per month were predictors of scores on the perceived stress scale (PSS).

   The results of the regression indicated that one predictor explained 10.4% of the variance ($R^2 = .104, F(5,68) = 1.59, p = .176$). The combined impact of the predictor variables did not have significant explanatory value, in relation to perceived stress levels. It was also found that client hours per month significantly predicted stress scores, to a negative moderate amount ($β = -.319, p = .012, 95\% CI = -.140 - -.018$), no other predictor variables significantly predicted stress scores; self-care hrs ($β = .030, p = .804, 95\% CI = -.081 - .104$), academic qualifications ($β = .030, p = .801, 95\% CI = -.918 – 1.185$), years accredited ($β = -.047, p = .700, 95\% CI = -.217 - .146$).

2. Multiple regression was used to test whether self-care strategies hours per month, personal therapy hours per month, academic qualifications, years accredited and number of client hours per month were predictors of scores on the burn out scale. The results of the regression indicated that one predictor explained 12.8% of the variance ($R^2 = .128, F(5,65) = .79, p = .105$). The combined impact of the predictor variables did
not have significant explanatory value, in relation to burn out scores. It was also found
that academic qualifications significantly predicted burn out scores, to a positive
minimal amount ($\beta = .282, p = .022, 95\% CI = .221 - 2.685$), no other predictor
variables significantly predicted burn out scores; self-care hrs ($\beta = -.057, p = .639, 95\%
CI = -.133 -.082$), personal therapy ($\beta = -.096, p = .418, 95\% CI = -1.374 -.577$), years
accredited ($\beta = -.094, p = .445, 95\% CI = -.292 -.129$), client hours ($\beta = -.167, p = .187,
95\% CI = -.119 -.024$).

3. Multiple regression was used to test whether self-care strategies hours per month,
personal therapy hours per month, academic qualifications, years accredited and
number of client hours per month were predictors of scores on the secondary traumatic
stress scale. The results of the regression indicated that one predictor explained 3.5%
of the variance ($R^2 = .035, F(5,65) = .467, p = .800$). The combined impact of the
predictor variables did not have significant explanatory value, in relation to secondary
traumatic stress scores. It was found that no predictor variable significantly predicted
secondary traumatic stress scores; client hours ($\beta = -.179, p = .179, 95\% CI = -.154 -.029$),
self-care hrs ($\beta = .078, p = .542, 95\% CI = -.096 -.181$), personal therapy ($\beta = -.001,
p = .996, 95\% CI = -1.260 - 1.254$), academic qualifications ($\beta = .089, p = .480,
95\% CI = -.1022 -.152$) years accredited ($\beta = .012, p = .923, 95\% CI = -.258 -.284$).

4. Multiple regression was used to test whether self-care strategies hours per month,
personal therapy hours per month, academic qualifications, years accredited and
number of client hours per month were predictors of scores on the compassion
satisfaction scale. The results of the regression indicated that one predictor explained
7.7% of the variance ($R^2 = .077, F(5,65) = 1.081, p = .379$). The combined impact of
the predictor variables did not have significant explanatory value, in relation to compassion satisfaction scores. It was also found that no predictor significantly predicted compassion satisfaction scores; academic qualifications ($\beta = -.175, p = .159$, 95% CI = -2.351 - .393), self-care hrs ($\beta = .089, p = .475, 95\% CI = -.077 - .163$), personal therapy ($\beta = .124, p = .311, 95\% CI = -.531 - 1.641$), years accredited ($\beta = .146, p = .252, 95\% CI = -.099 - .370$), client hours ($\beta = .012, p = .929, 95\% CI = -.076 - .083$).

**Graphs depicting relevant data:**

![Profile plot](image)

**Figure i:** Profile plot depicting marginal means for perceived stress, governed by number of self-care strategy groupings and private or public employment.

The above profile plot indicates that mean perceived stress scores fall, for those in private sector employment, as the number of self-care strategies employed increases. Perceived stress scores also fall for those in public sector employment, as strategies employed increases from zero to two, but rises, somewhat, again from two to three.
Figure ii: Bar graph depicting count of participants for relationship status.

The above bar graph indicates relationship distribution for participants (N=76) as follows; married (N=45, 59%), widowed (N=5, 7%), divorced (N=7, 9%), separated (N=3, 4%), single co-habiting (N=8, 10.5%) and single (N=8, 10.5%).

Figure iii: Pie chart indicating count of participants, for different age categories.

The above pie chart indicates the different age categories for all participants (N=76), as follows; 35-44 years (N=10, 13%), 45-54 years (N=23, 30%), 55-64 (N=37, 49%) and 65-74 (N=6, 8%).
Figure iv: Bar graph indicating count of participants, for different academic qualifications categories.

The above bar graph indicates academic qualifications for all participants (N=76), as follows; diploma (N=14, 18%), higher diploma (N=11, 15%), degree (N=17, 22%), masters (N=32, 42%) and doctorate (N=2, 3%).
Qualitative

Introduction:

As a result of the interviews conducted, the transcription of same, and the IPA analysis of the data, the following findings came to light. These findings can be subdivided into frequencies of key words and analysis of themes, which will be stated sequentially.

Frequencies of key words:

The analysis of frequencies of key words, within each individual transcript, revealed the following:

<table>
<thead>
<tr>
<th></th>
<th>Burnout</th>
<th>Stress</th>
<th>Satisfaction</th>
<th>You Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiona</td>
<td>0</td>
<td>51</td>
<td>4</td>
<td>204</td>
</tr>
<tr>
<td>Mary</td>
<td>2</td>
<td>9</td>
<td>2</td>
<td>64</td>
</tr>
<tr>
<td>Anne</td>
<td>1</td>
<td>26</td>
<td>1</td>
<td>170</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>86</td>
<td>7</td>
<td>438</td>
</tr>
</tbody>
</table>

Table xiv: Frequency of repetition of key words, within transcripts, governed by interviewees.

Analysis of themes

As a result of the use of interpretative phenomenological analysis methodology, the understated superordinate and subordinate themes were uncovered. These themes will be assessed systematically, with relevant vignettes to support each. Each vignette will be linked to the appropriate interviewee and question/section of each transcript, as follows PT.1 - 2(A) equates to interviewee one, question 2, section A. Interviewees were allocated the pseudonyms Fiona, Mary and Anne respectively. In order to protect the anonymity of each interviewee, any revealing information, within vignettes, has been removed and replaced by an appropriate explanation, contained within brackets i.e. Starbucks becomes (named organisation).
<table>
<thead>
<tr>
<th>Superordinate Themes</th>
<th>Compassion Satisfaction</th>
<th>Self-Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress &amp; Compassion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Stress</td>
<td>i) Internal Factors</td>
<td>i) Supervision</td>
</tr>
<tr>
<td>ii) Burnout</td>
<td>ii) External Factors</td>
<td>ii) Support</td>
</tr>
<tr>
<td>iii) Secondary Traumatic Stress</td>
<td>iii) Satisfaction</td>
<td>iii) Self-Care Strategies</td>
</tr>
</tbody>
</table>

Table xv: *Table indicating superordinate and subordinate themes.*
Stress and compassion fatigue

Throughout the transcripts, there are multiple references to stress and compassion fatigue, though references to one concept are noticeably absent, in interviews that started with an explanation of all the concepts under investigation. This superordinate theme is broken down into its three constituent parts (subordinates) 1. Stress, 2. Burnout and 3. Secondary traumatic stress.

Stress:

All three interviewees spoke very openly about stress, regardless of levels and impact, there was unlimited examples of how working with crisis, conflict driven or entrenched clients impacted on the interviewees Fiona “very, very stressful”, Mary “a cause of stress as well, which so impacts on the work.”, Anne “those clients stress me. I find that very stressful”, the type of client differed for each of the interviewees, whereas the effects did not:

Fiona gave a good example of when the two worlds, of work and personal life, collide:

PT.1- 3(B) Fiona: “I think probably another big challenge is coping with major events in your own life and still being available you know and avoiding eh, avoiding work becoming a refuge from your own trauma, you know.”

Mary echoed Fiona’s sentiment:

PT2 – 11(B) Mary: “There would have been a spate of things with young people where you'd feel a bit under pressure plus then other things in your personal life and that would be a…..”
Fiona also gave a good example of work overload and its effect:

PT.1 – 11(C)  **Fiona:** “If you're seeing too many people first of all you start making mistakes in your diary. So then that's very stressful. So then you've got double bookings, that's really stressful.”

Control was also an issue that recurred throughout the three interviews, especially for Fiona:

PT1. – 1(B)  **Fiona:** “So I was working in the public service and I wanted more control over my life I guess.”….. 5(A) “So being in control also meant you had control of your costs, but I imagine it would be stressful.”…. 7(D) “These are the things that actually matter to me, you know, and I can pick and choose the work I do.”….. 8(C) “So no again I think because I am in control of my work I don’t have to really spend time worrying about what I should do.”

Anne supported this distinction and stated it in terms of how it made her feel:

PT.3 – 3(E)  **Anne:** “If I had been working in private practice I wouldn’t have had to deal with that. I would have just made my best decision and gone with it.” (quite angry)

Each interviewee also gave an example of serious retrospective stress, but in each case, at some time in the interview they also wanted to assure that this was not the case anymore. Connection also appeared to be lost with the interviewer, when relating these incidents, the interviewees appeared to reflect or re-live these experiences. There was pain, anger and distress in the room:
Fiona gave a somewhat angry example, this was reflected in the use of the word “nice” and the tone and physical postures:

PT.1 – 9(A)  **Fiona:** “I had a difficult kind of decade I suppose when I was looking after elderly parents and didn’t have much opportunities to train and go to nice workshops, so there was a kind of a pause on my development I think.” (slightly angry, eye contact broken with interviewer, stares off into space)

Fiona had assured earlier in the interview, that she was not stressed anymore:

PT.1 – 7(D)  **Fiona:** “So by and large honestly, it’s not that stressful anymore cos I think I’m OK with, I’ve got good supports, I’ve got a good working environment.”

Mary gives a good example of exposure to extreme stress, the life v’s death drives (Freud, 1920):

PT.2 – 9(C)  **Mary:** “But I think of when I was on the phone line talking to someone who was about to commit suicide in the middle of the night you know. And I had very little training then……Yes but you’re going with your human gut instincts as how best you connect but that’s probably not something that one could sustain for very long……That’s kind of a burn out thing exactly.”

Mary gives an example of extreme stress, but opens by qualifying its retrospective nature:

PT.2 – 11(B)  **Mary:** “And then Yes. I'm thinking of maybe four or five years ago. Four years ago maybe. There would have been a spate of things with young people where you'd feel a bit under pressure plus then other things in your personal life and that would be a… I was worried about myself when personal things were difficult and the work was also quite difficult and that combination was bad.” (eye contact broken, stares up to the right)
Anne’s example of extreme organisational stress and its impact, is also qualified by how she worked it out:

**PT.3 – 3(E)**

**Anne:** “I was, I mean I had to take 4 weeks off work I was so stressed, with the organisation. You know, but I worked it out, you know…. (eye contact broken)…… I knew I wouldn't sit in front of someone and if any of them gave me an argument I’d probably burst into tears. So that's not. You're not functioning.”

**Burnout:**

Burnout is noticeable by its distinct lack within the dialogue of the interviews. Fiona, probably, best sums up this. At the very end of the interview, when she had been assured that the recording had been terminated, she proceeded, quite frantically, to relate how she could fully understand how someone who was overworked, who was working within an organisation, could become depersonalised, could give up hope and could be unable to relate to clients. The impact of this exchange on the interviewer, could best be described with reference to the freeze response (Levine, 1997; Rothschild, 2000), frozen, shocked and stressed, a feeling that lasted for an hour or two, post interview. Other references, by the other interviewees were neutral or incomplete:

Mary, singularly, implicates herself in this concept, but even as she does, she stops, thinks, and then decides to state it:

**PT.2 – 11(B)**

**Mary:** “It wouldn't have been the work that would have made me feel like that. I have been in places where I've thought I wonder am I burned (breaks contact, eyes look up, to the right)….am I getting burned out or am I in a bad place - it would have been to do with personal issues worrying about other people.” (so the work cannot be the problem)
Anne implicates the helplessness of not being able to help clients or not being able to give them what they need and its ramifications:

PT.3 – 5(A)  
**Anne:** So not being able to provide what they (clients) need or help, you know, so I suppose maybe this is a kind of burnout, if you don’t get any satisfaction from your work.”

**Secondary traumatic stress:**

All three interviewees were very open about secondary traumatic stress and its impact. This concept would appear to be inter-linked with transference, counter-transference (Freud, 1912) and the wound(s) of the therapist. Technically speaking these concepts are not within the definition of STS (Stamm, 2010). However, in reality the transference and counter-transference of the therapist will be rooted in their own world (as well as the clients) and it would seem naïve to believe that this does not affect the impact of STS:

Fiona begins, but the same occurrence is supported by all three interviewees:

PT.1 – 5(B)  
**Fiona:** “I definitely find it stressful if a client is bringing issues that are mirroring something that’s going on in my own life. So we need a lot of supervision around that. If you’re aware that somebody’s triggering you about stuff, that’s actually very close to the bone and you could have swapped chairs. You know, that can happen.”

Anne also stated the impact of counter-transference:

PT.3 – 3(A)  
**Anne:** “I think it is probably that there’s a crossover between the client. It’s a kind of what the client is trying to work with and whatever my….. it’s where kind of my stuff and their stuff interacts. That has been the most challenging.”
**Compassion Satisfaction**

This superordinate theme is broken down into three subordinate ones 1) Internal factors, 2) External factors and 3) Satisfaction. The first two are seen as effecting the ability of the third. In those parts of the interviews, where the focus was on the positive side, there was a very real sense of pride, gratitude and contentment from the interviewees, the atmosphere in the rooms seemed to change, the pace of the interview slowed, almost to a kind of peace or tranquillity.

**Internal factors:**

Internal factors could just have easily been called the therapist as individual, in that this theme involves the awareness, experience, self-belief, process and self-development of the interviewees. These factors are seen as being a source of resilience against stress and compassion fatigue, as well as an aid to experiencing compassion satisfaction and informs many of the choices in the third superordinate theme.

Fiona demonstrates elements of awareness, self-development and confidence:

PT.1 – 5(B)  **Fiona:** “You see I think I’ve tried to avoid an awful lot of the stress in the last while.”

PT.1 – 4(B)  **Fiona:** “I’m really interested in the skills and the knowledge and the experiential and the self-development and I got all of that in spades.”
Fiona: “You kind of learn… I can see look I’m booked up all through April and you know so if somebody rings me up today and says, you know, I’m a new client I’d like can you take me on I’m looking at that and saying no…... That’s a skill, you know. I think the most stressful thing in our work is to do too much of it and then it becomes really, really awful……”

Anne and Mary demonstrate self-compassion and confidence, from a different perspective:

Mary: “Yes. I think I am finding it increasingly more satisfying. I think you just grow and you can just - I may not be answering your question - but I think I or one can only grow in confidence over time so I try not to give myself a hard time about that. So yes I find it more satisfying I think. Just by virtue of having an increasingly solid foundation.”

Anne: “…we're all middle-aged, in our late middle age, you know that there’s a kind of an agreement that if you’re overloaded that you can say look I can’t I need someone fairly straightforward now. I can’t take on someone complicated.”

Mary also demonstrates the internalisation of the secure base (Bowlby, 1988)

Mary: “Yes I suppose it’s like the mother and baby. The good mother…… The merging and then you can go forward and play happily and take a few risks. Yes. That’s important as well. To be confident enough and to be secure enough almost if you want.”
Anne also demonstrates awareness socially and in her work and demonstrates control and support, in being able to say no:

PT.3 – 6(A)  

Anne: “Yes and I think for me, if my stress level is very high, going out and socialising doesn't help because all I could do is just drink you know and I actually don't get any release, just kind of switch off.”

External factors:

External factors relates to those factors which support the therapist in attaining satisfaction from their work, similar to the internal ones, these could also be seen as preventative, in relation to stress and compassion fatigue. However, these factors are unique in that they are external to the individual, they cannot be self-generated:

Fiona, who is also a supervisor, in the below extract is talking about the experiences of a supervisee. However, what seeps through is her anger and there was the intense feeling that this has been her own primary experience of public sector organisations, as well:

PT.1 – 7(C)  

Fiona: “It’s such a sick system. I'm so glad I don't work in it anymore. It’s dangerous you know. It really is dangerous for people’s practice and for their own personal and professional wellbeing I think in many cases. You know it’s like that quote, ‘can an ethical man live in an unethical world’……..Can a true professional work in the (public sector organisation).”

Fiona also shows her recognition of factors beyond her control:

PT.1 – 2(C)  

Fiona: “I mean obviously you know the privilege of working with people and seeing them getting you know making improvements, but you know you don’t always get that…..”
Mary talking about being held and supported by her organisation, ends up questioning whether the organisation is in fact supportive, meaning at some stage she has at least felt, that it is not:

PT.2 – 5(C) Mary: “…..and then referring onwards or you're also kinda trying maybe to hold someone who has got a referral, but waiting. So in that sense it's a sense of yes, of how much the institution, in which you work or your own network, is supportive of you or not.”

Mary expresses the wish, for psychotherapy, at some level to be her secure base, to let her know that it’s ok, to be not ok. This almost felt like a plea, whether to supervisors or associations or to the profession in general, remained unclear:

PT.2 – 11(D) Mary: “Yes, so that’s, Yes, I think what psychotherapy hopefully has, is that support system where people can be not OK. That when we're in a bad place we can say, this is not good at the moment, rather than having to toughen up.”

Anne, similar to Mary and Fiona, also tells us the importance of client balance, to have some clients who are progressing:

PT.3 – 11(A) Anne: “…..if you have people who are, you know, less wounded. They can make a recovery quicker, so if you have some of the other clients is slower much slower, so there's clients where you think you're going nowhere. You know they're going nowhere, you're going nowhere with them and it's hard to get any satisfaction out of the work you know…..”

Anne demonstrated that contrary to Fiona and Mary, there are organisations which support therapists and let them know it is ok, to not be ok:

PT.3 – 5(B) Anne: “You know and again there's good support in the centre…….. Because there is a good network, there is a kind of safety net. You know, but they are open to you saying, look I actually am not functioning…..They are good. …… they do know about secondary post-traumatic stress you know. So there is a lot of support around that”
Satisfaction:

Satisfaction, in psychotherapy, is the positive feelings therapists get as a result of working with clients. All three interviewees expressed these experience and their faces, mood and physical expressions reflected entering a happy frame of mind (smiling, eyes bright, shoulders dropped and jaws loosened).

Fiona was smiling as she stated this and there was passion in her voice, this was a very real moment:

PT.1 – 10(A)  
Fiona: “…..but I think we're privileged in that the work we do is about trying to make a difference in people's lives and if you do that at all then or even if you try to do that, you know, or even if they try to do it, I think that's, that's just the best thing about it, you know, so I think that sounds a bit altruistic but, that's it really.”

Similarly, the passion and belief behind Mary’s comments, brought a sense of privilege and satisfaction into the room:

PT.2 – 11(C)  
Mary: “That’s massive you know and the privilege of being included in someone's life…….Yes absolutely of getting to see behind the scenes is yes is a huge thing yeah. And in a world where things can be very superficial and shallow and the wrong kind of values are seen to hold sway, it’s pretty amazingly special to be able to work at something which is not about that. Which is absolutely authentic.”
Anne similarly, brought passion to this extract, but it was touched with sadness and happiness, possibly sadness at her wound and happiness that she was able to treat this wound in others, this was a highly emotive moment and the tears swelled in the interviewer’s eyes also:

PT.3 – 11(A)  

Anne: “Meaning? I think it’s a lot to do with meaning. Probably kind of unconscious and conscious kind of wishes you know, like wanting to offer a space to someone that I would have wanted myself, you know. You know everyone has a right to be heard and to grow you know. So that’s going to make me emotional now but……. (crying)"

Self-care

Self-care involves the measures that individuals take, to ensure that they are grounded, balanced and stable, both in their work and in their lives, the two of which are indistinguishable, as they both represent a part of the individual, in their synergistic whole. The third superordinate theme, self-care, is divided into the three subordinate themes of 1) supervision, 2) support and 3) self-care strategies.

Supervision:

It is acknowledged that it could be argued that supervision belongs under the support theme (O’Connor & McQuaid, 2013), however, its mandatory nature and its prevalence and emphasis within the transcripts, warranted it a unique theme in this analysis.

When asked what helped her deal with stress in her work Fiona was quite emphatic and unhesitant:

PT.1 – 2(A)  

Fiona: “Supervision…..Supervision, supervision, supervision.”
Fiona also demonstrates how supervision can act as a secure base, in its own right:

**PT.1 – 9(A)**

Fiona: “So I was admiring her work (supervisor) and you know emulating her and she said we all have to find our own way to practice. We all have to find our own way and I remember thinking I just want to be like you, you know. You're so great and then realised I know what she means you actually have to find your own way of working, that brings yourself into it and both the best of you and the worst of you, being aware of those things….”

Mary demonstrates, in this extract, the importance of supervision to her as an aid to the work and as a therapist:

**PT.2 – 2(A)**

Mary: “Having a supervisor that you can talk to and be honest with and is supportive, is a big plus or minus.”

In the following extract Mary tells of when things were bad for her, how she depended on her supervisor, it almost felt like the good enough mother (Winnicott, 1986) was in the room with us:

**PT.2 – 11(D)**

Mary: “I was worried about myself when personal things were difficult and the work was also quite difficult and that combination was bad. Yes and I would have talked about that in supervision and at least having that sounding board, so that my supervisor didn’t say no you shouldn't work, but you know, but at least you could have that conversation and say I think I'm cracking up at the moment or I feel, you know, things are falling apart……so I would have been held by that.”
In this extract Anne outlines the support her supervisor gave her, with the wording Anne uses you can almost visualise the child venturing out and exploring, while being supported, something she herself names at the end:

PT.3 – 3(B)  
**Anne:** “My supervisor didn’t know what was going on. But she didn’t get judgemental. Her own anxiety didn’t move to judgement and sureness. Do you know…..So she was able to support me while I got information from other places. But able to support me to provide the kind of relationship support that I needed to kind of venture out and find what I needed to find out….. Yes exactly, very much so, I think she provided a secure base.”

Anne also expresses the importance of supervision for her, as well as personal therapy, it was obvious in this extract, how essential those supports were for her, during those bumpy times:

PT.3 2(A)  
**Anne:** “Yes I suppose a big support has been kind of, when the shit hits the fan kind of time, has been good supervision and a good therapist.

**Support structures:**

Research (Maslach, 2001; O’Connor & McQuaid, 2013 informs us of the importance of support structures, in the prevention of stress and trauma and on that basis, these support structures are also seen as an essential element of self-care.
Fiona began by indicating the importance of peers:

PT.1 – 2(C)  **Fiona:** “But you know the thing that actually supported me most when you actually think about those years we had such fun, black humour, you know, good lunch breaks together, yeah collegiality ….. Yes colleagues and supervision that’s what keeps me going.”

Fiona indicated the importance of peers in her life, not just her work:

PT.1 – 9(C)  **Fiona:** “Yes I got quite isolated by, you know, but for the practice (peers) and the support there in that, they were like my family. They were really, they were so important, they still are as friends.

Fiona also indicated the importance of family and other social support:

PT.1 – 6(A)  **Fiona:** “Family and friends, I mean honestly John's (not real name) great and I mean I can debrief on him a fair bit.”

Mary, uniquely indicates the importance of group therapy for her, as a support structure:

PT.2 – 2(A)  **Mary:** “Being in group therapy has been hugely useful as part of my training and as a support and it has made a, I would say the biggest difference in terms of me getting support outwards in different ways.”

Mary also indicated that she was in a peer support group, but had forgotten it due to how busy her life is:

PT.2 – 6(C)  **Mary:** “O yes sorry. I'm in a Peer support group yes. I am in a peer group. So I am actually doing an awful lot of……Supervision and support and stuff yes.”
For Anne, the biggest support was personal therapy and she had found the type of therapy that suited her, body focused. The interview with Anne was probably the most emotional of the three, there was a real sense of her being emotionally open, to her clients and in her life, so she had found the type of therapy that helped her process this:

Anne: “EMM.. Therapy. Cause it’s really, cause its body focussed I can really feel, you know, and see the effect on my body. You know. So kind of I come to my therapy session and I let it go. So it kind of clears it. Keeps clearing it.”

Similar to Fiona and Mary, Anne also spoke of the importance of peers, family and friends:

Anne: “Well I have colleagues….. and I have some very good friends also in the area, who you know I could ring up at any time and. Peer support yes, yes…. A good personal life, a good relationship and even though my husband doesn’t know anything about as he calls it the psycho world… You know, he’s very supportive.”

Anne also emphasised the importance of a social network, which is not peer based:

Anne: “But in general it depends, keeping your life balanced, kind of my non psychotherapy friends are good, because this is all Greek to them… Yes or they you know they talk about you know light things and they want to have fun and it’s not that my psychotherapy friends don’t have fun but, we can end up talking about our day to day struggles. It can be heavier work.”
Self-care strategies:

Self-care strategies reflects the active strategies that therapists employ in order to protect and nourish themselves. These are seen as essential to their lives as therapists and human beings. All three interviewees gave good examples of personal self-care strategies and in all three cases this was unique, and suited to the individual:

Fiona’s extract here shows her awareness, in that breaks and holidays are important, but she finishes with something that is consistent and probably much more important, time to herself:

PT.1 – 11(D) Fiona: “Yes, Yes and you know plenty of breaks is important as well. Looking forward to breaks. “…..and holidays - I love holidays - and travel…..Didn’t do enough of that either. Having just time to yourself. That would definitely be a big one. I mean I'm basically an introvert so, you know, I actually need time alone …..”

Fiona demonstrates a knowledge of recognised strategies and their benefits, but does not consistently apply them:

PT.1 – 6(A) Fiona: “What else. I know one should exercise and meditate and do all these things. I don't do a lot of that, you know…….. I do these things, but I don't do it in any disciplined way, but when I do that I definitely appreciate the benefit of it…..”
Similar to Fiona, Mary lists those things that suit her, massage, connecting to nature, music, cooking, and reading. Also, similar to Fiona, Mary recognises the positive effects of other strategies, but does not employ them consistently:

PT.2 – 6(A) Mary: “I'm not very sporty but I did a lot of kayaking last summer. Like that's not practical on a week working in the city, but things like that are very, very good. I'd love to say swimming but I don't. I have a gym membership I don't use”

Anne demonstrates recent additions to her strategies, in the form of hobbies and also the importance of regular recognised activities (O’Connor & McQuaid, 2013; Pearlman, 1995) in yoga and running. Anne’s choices are confirming of her emotional openness, in that, similar to body focused therapy, physical exercise would provide a good way to release stress (Pearlman, 1995), as she states herself:

PT.3 – 2(C) Anne: “Yes and this year I have done things I should have done long ago and like I have joined a book club. I’ve joined a choir.”

PT.3 – 6(C) Anne: “Yes. (Pause) I think a lot of kind of routine practices like I do yoga. I do a bit of running or slow jogging. That is actually a good stress buster. Something that burns off the adrenalin.”

Summary:

The data yielded through IPA analysis of the three interviewee’s transcripts has proven to be rich and highly informative. This data will be discussed in detail in the following discussion section.
Section 4: Discussion and Conclusions

Study orientation:

The aims of this study were threefold, to establish strong quantitative baseline data, for integrative psychotherapists in Ireland, as regards demographics, stress, compassion fatigue, compassion satisfaction and self-care strategy levels. To explore statistical correlations (in combination and individually), for predictive levels, between stress, burnout, secondary traumatic stress, compassion satisfaction and self-care (measured by self-care hours per month). To demonstrate, how both quantitative and qualitative research methods, can be used co-operatively, to strengthen research and investigation methodologies. The aims of this study will now be addressed, from the perspectives of results (quantitative, qualitative and co-operative), and how these relate to previous research. Limitations of this research and recommendations for future research will then be given. Finally, a conclusion will be stated.

Interpretation of results

Quantitative:

Inferential statistics indicated the following results. Client hours per month significantly predicted perceived stress scores to a negative moderate amount ($\beta = - .319$, $p = .012$). This indicates that, controlling for other predictive variables, therapists with higher client hours per month, were expected to have lower perceived stress scores. This may indicate a validation of their abilities, as a result of the number of client hours per month. Academic qualifications significantly predicted burnout scores, to a minimal positive amount ($\beta = .282$, $p = .022$), indicating that, after controlling for other predictive variables, therapists with higher academic qualifications, were expected to have higher burnout scores. This result makes little
sense from the perspective of previous research, which indicates that education and professional development act as moderators against negative concepts, such as burnout (Linley & Joseph, 2007; Follette, Polusay & Millbeck, 1994; O’Connor & McQuaid), the reason for this is unclear. It should be noted that this result was minimal. However, this result and the fact that no other significant predictive correlations were discovered, within the statistical analysis, despite research which indicated predictive values for some of these concepts (ibid), may point to a problem with the sample size. This is discussed more fully in the limitations and recommendations sections.

However, an analysis of a profile plot (Graph i), depicting marginal means for perceived stress, governed by number of self-care strategies employed and private or public employment, demonstrates some interesting results. In the private sector graph line, mean perceived stress scores drop dramatically, as the number of self-care strategies increases. In the public sector graph line, mean perceived stress scores also decrease as the number of self-care strategies increase, with a slight increase from two to three strategies. This would seem to indicate that the amount of self-care strategies employed has a positive effect on perceived stress levels. However, a similar analysis involving burnout, secondary traumatic stress and compassion satisfaction scores, did not yield any consistent results.

The analysis of raw scores indicated that twelve participants scored high for secondary traumatic stress and the same amount (though mostly different participants) scored high for compassion satisfaction. However, as Stamm (2010) rightly cautions, the ProQol is neither assessment or diagnostically based and merely represents scores at a snap-shot in time and that a persistence of scores over a continuous period of time i.e. every six months, is more indicative
of cause for concern. Further, Stamm (ibid) cautions that single scores should not be assessed, but combination scores, across the three concepts. Stamm (ibid) also indicates that individual strategies i.e. additional supervision, changes to work environment are appropriate, only when continuous levels of negative scores are assessed, across time. The analysis of perceived stress scores indicated that eight participants scored under five, with one scoring zero, this appears unlikely, and may indicate underreporting or choosing the right answer (consciously or unconsciously), rather than the real answer. Further, the analysis of self-care hours indicated that thirteen participants indicated less than five hours, with one indicating zero, this also seems unlikely, and this may point to a problem with the options provided for self-care strategies and assessment based on total hours per month, which is further discussed in the limitations section.

A further point of interest, is that originally eighty-one therapists participated in the questionnaire, five of these had to be removed as they did not complete the questionnaire, of those five, four stopped at the exact same place, the first question on self-care strategies. This may represent an unwillingness to participate in research, where personal weaknesses are indicated, an ego defence (Freud, 1921), this could also be supported by the four participants who did not complete the ProQol.

Qualitative

In general, this analysis yielded a high level of divergent themes, all of which cannot be evaluated due to the limitations of word count. Accordingly, only the main themes will be examined, in sequence.
Analysis of word frequencies:

The analysis of frequency of key words, within each transcript, indicated that the word burnout only appeared three times. This supports the assertion by previous research, that burnout is perceived as stigmatising and labelling (Elwood, Matt, Lohr & Galovski, 2010; Fahy, 2007; Figley, 1995, O’Connor & McQuaid, 2013), this may also indicate a form of unconscious ego defence (Freud, 1921), what’s not talked about is not real. In contrast, the word stress occurred eighty-six times, which indicates its acceptable nature. The word satisfaction only occurred seven times, however, a review of the transcripts indicates that other words with similar meaning (i.e. happiness, joy), were also used. Interestingly, the words “you know” occurred 438 times within the transcripts, this may be indicative of the fact that the interviewer knew the interviewees scores or the subject matter of the research, or merely the overuse of a south-side idiom, this remains unclear, but the frequency of occurrence may warrant further investigation.

Stress and compassion fatigue:

It is patently obvious from this analysis, that Stress would appear to be the acceptable face of psychotherapist’s distress. The transcripts are rife with multiple references, whether retrospective, extreme, acute or chronic. Each interviewee elucidated the difficulties associated with complex clients, though individually these were different for each one, indicating the individuality of each therapist (Chrestman, 1995). One issue, which came up very strongly, was control, which was indicated very strongly by Fiona (see montage of vignettes) and to a slightly lesser degree by the other interviewees. This is in keeping with previous research, on stress (Petrosky & Birkimer, 1991), this may represent the catalyst for burnout and chronic stress, as a perceptions of a lack of control may lead to the helpless/hopeless state, associated
with such conditions (Bonner & Rich, 1991; Cherniss, 1992; Maslach & Leiter, 1997; Maslach & Leiter, 2008; O’Connor & McQuaid, 2013), accordingly future research should consider such factors.

Burnout, in contrast, represents a lack, a lack of inclusion in the dialogue and a lack of acceptance. This may represent the lack that therapists feel in association with the concept, this is demonstrated very strongly by Fiona’s only speaking about it off record, the other two interviewees made some reference to it, but always in a defended way. This is supported in previous research by reference to stigma/ labelling associated with these extreme negative concepts (Linley & Joseph, 2007; Follette, Polusay & Millbeck, 1994; O’Connor & McQuaid). However, an element of monetary reality may be attached to this as well, as in if I cannot work with clients, how would this impact on my financial reality. This is not to deny the ego defences (Freud, 1921) of being the ideal or good enough therapist (Winnicott, 1986), but a grounding in reality as well. Secondary traumatic stress was also spoken about very openly in the transcripts, and the role of transference and counter-transference (Freud, 1912) of the therapist (their wound(s)), as well as the clients, was also assessed as being of high importance.

Compassion satisfaction:

Internal factors or therapist as individual, was considered to strongly moderate stress and by definition, other negative concepts. The roles of awareness, experience self-esteem, self-development, internal supervisors (Casement, 1990) were shown to impact, not just on the negatives, but on the positives as well. Therapists must be aware of their own processes, their own limits, their own individual stressors (which are unique to the individual) and utilise strategies to compensate, in order to limit the negative and accentuate the positive factors
associated with psychotherapy. With regard to external factors, the importance of client balance, client change, organisational support and the effects of a lack in any of these areas was strongly emphasised, and this supports findings in previous research (Adams, Boscarino & Figley, 2002; Follette, Polusay & Millbeck, 1994; Sheehy & Friedlander, 2009; O’Connor & McQuaid, 2013). Satisfaction was probably the most rewarding part of these interviews, the mood lessened, the pace of the interviews slowed. There was also a very real feeling of privilege, by both the interviewees and the interviewer, all of the interviewees demonstrated this concept, both in their work and in their lives, both of which are seen as being interrelated. These feelings and there interdependency is also supported by previous research (Figley, 2002; Linley & Joseph, 2007; O’Connor & McQuaid, 2013).

Self-care:

The important role played by supervision, in supporting therapists and the security and secure base (Bowlby, 1988) which it provides, was very evident from the transcripts. The role of supervision, in this regard, is sometimes overlooked, due to its mandatory nature. However, its emphasis and impact by all three interviewees, was emphatic. There is some support for this in previous research (Linley & Joseph, 2007; O’Connor & McQuaid, 2013), though it is often under emphasised. Of all the factors, supervision was the one most strongly emphasised by the interviewees and ranks it as the front line of defence against negative factors and an essential part of validation and positive aspects of psychotherapy. In keeping with previous research (Linley & Joseph, 2007; O’Connor & McQuaid, 2013; Thompson, 2003), personal/group therapy, peer support and social support all rated highly, as ongoing supports for the interviewees. However, there was one proviso, that when these supports were going badly, this combines to accentuate other negative factors, in the interviewee’s lives. Interestingly, self-
care strategies were unique for each interviewee, one valued holidays and alone time, one massage and gardening and one utilised running, yoga and meditation. All three acknowledged the positive effects of strategies like meditation and mindfulness, but admitted to being inconsistent in their practice. Of further interest, is the interviewee who consistently engaged in physical exercise, yoga, meditation and body-focused therapy. Anne is highly representative of the awareness, discussed earlier, in that she had the highest STS and CS scores, of the three, possibly from a high affect style (Cerney, 1995). Interestingly, this interviewee also had the clearest boundaries, which is supported as a self-care strategy, in previous research (Cerney, 1995; Neuman & Gamble, 1995). This can be translated, as an adaptation to necessary circumstances, awareness of one’s own process, and what is needed to limit exposure to stressors or negative concepts. Accordingly, it is maintained that individual therapists compensate for their own process (through awareness) and adapt their self-care, to what is considered necessary, for their own self-maintenance. However, this presupposes a knowledge of one’s own process and vulnerabilities, which was extremely evident in association with the three interviewees.

One matter of further interest was the strong statement, interpreted as a plea, by one of the interviewees. Mary’s request for it to be acknowledged “that it’s okay, to be not okay”. This was seen as an affirmation of previous statements (Figley, 2002; O’Connor & McQuaid, 2013) and goes to the heart of the problem, as regards the negative concepts and stigma/labelling (ibid). That therapists require reassurance that suffering from these negative conditions, which are all transient and treatable (Hayes, 2013; Maslach & Leiter, 1997; O’Connor & McQuaid, 2013), is normal and is a risk that all therapists are subject too.
Co-operative:

The quantitative statistical analysis demonstrated a lack of high scores, for burnout/stress, this was confirmed by the qualitative analysis. However, due to the rich nature of quantitative analysis it was able to demonstrate, retrospective incidents of chronic stress or burnout, in the past lived experience of the interviewees. This further confirmed the transient and treatable nature of such conditions and pointed to directions for future analysis i.e. less experienced therapists or students. Further the qualitative analysis demonstrated stigma/labelling attached to such concepts, as asserted by previous research (ibid). This may indicate elements of underreporting, which is supported quantitatively by participants not completing certain sections of the questionnaire.

The quantitative analysis did not find significant statistical correlations between self-care strategies and negative or positive concept scores. However, the qualitative study indicated the effectiveness of self-care strategies for prevention of negative concepts and as aids to positive concepts, indicating a problem with the study’s methodology related to sample size, measurement, or both.

Quantitative statistical analysis also indicated some high scores in STS and CS and the qualitative analysis demonstrated moderators of these concepts i.e. transference and counter-transference, not only from the clients, but from the therapists themselves. Further, the qualitative research indicated how high affect connection could result in more STS impact for therapists, but that this could also lead to greater CS. The quantitative analysis also indicated some low self-assessment in self-care hours per month, by participants, with one indicating zero hours, this seemed unlikely. The qualitative analysis was able to add to this analysis, by
indicating the diversity of self-care strategies utilised by the interviewees, drawing attention to how they had been measured in this study.

**Limitations:**

The number of participants (N=76) for this statistical sample and analysis is borderline. This highlights an important lack for quantitative analysis of psychotherapists in Ireland, which is discussed further in the recommendations section.

Self-care strategies could have been more fully explored in the quantitative analysis, by the inclusion of more options i.e. hobbies/diet in the questionnaire. Further, it would have been more beneficial to ascertain hours per month spent on individual strategies, rather than total figures only.

The focus of this study on accredited therapists only, limited this research. The data revealed that lesser experienced therapists are, possibly, more susceptible to negative concepts. Accordingly, a case could be made for a comparative study, involving students (seeing clients), pre-accredited and accredited therapists, of various experience.

Due to the stigma/labelling (ibid) conditions attached to the negative concepts under investigation and the negative effects/affects associated with such temporary conditions, it is naïve to expect these individuals to participate in research associated with them. In reality, this is probably the last thing they would wish to do. One possible solution is offered to this, which was highlighted in this research, in the recommendations section.
**Recommendations:**

Strong quantitative research requires relatively large samples, generally in excess of one hundred participants. Currently there is no effective conduit to therapist populations in Ireland willing to participate in research. This research has emphasised that point (see methodology), the conduit offered by IAHIP, though laudable, proved ineffective. This research has demonstrated this fact and also that there are therapists outside this conduit who are willing to participate in research. However, the channels accessed are far from ideal, but will continue to be explored until an alternative is made available. This channel could be created by associations e-mailing current members, and asking them if they wished to participate in research. A list of e-mails could then be held by the associations and research requests forwarded to those who have indicated a willingness to participate, similarly new members could be given this option. This recommendation is aimed at all organisations/associations involved in promoting psychotherapy, such as IACP (Irish Association of Counselling and Psychotherapy), IAHIP and IPA (Irish Psychoanalytic Association).

This research sample was drawn exclusively from IAHIP accredited therapists, on the basis that these members had similar training, orientation, and met similar accreditation requirements, thus reducing confounding variables. However, it was found that this was not the case in some areas i.e. orientation. Accordingly, it is recommended that future research in this area should draw from a broader range of associations, this also has the added advantage of increasing the likelihood of larger samples.
Given the relevance of control in the qualitative section and in previous research (Petrosky & Birkimer, 1991), the inclusion of a measure of perceptions of control, such as Rotter’s (1966) internal-external locus of control scale, would add to future findings.

Research in this area has consistently identified stigma/labelling and possibly fear (ibid) associated with the negative concepts (burnout, vicarious trauma) under investigation in this study. This research has indicated that this is not the case with stress, no matter how extreme. Therefore, one possible solution would be to investigate these concepts under a stress spectrum/continuum, similar to the way autism is described in the DSM-V (APA, 2015). All of these concepts are seen as having their roots in stress and as such, extreme concepts could be seen as representing one end of the spectrum.

However, the above is probably a long-term project. In the short-term, this research has also identified supervision as the front line of defence against the negative concepts under investigation. This position of supervisors, offers a unique opportunity for researchers, to investigate these negative concepts, from a secondary perspective. Accordingly, it is recommended that investigation of these negative concepts, from a research perspective, could be carried out using supervisors as participants, thus eliminating stigma/labelling and other censorship factors. In addition, each supervisor carries the life experience of each of their supervisees. A further factor of investigation, involved in such research, could be the stress, fatigue and satisfaction levels, of these supervisors.
Conclusion:

This research has generated strong, quantitative and qualitative baseline data, in relation to integrative psychotherapists in Ireland. Although only weak support was found for the hypotheses stated, possible reasons for this were emphasised and recommendations were made as to how these could be overcome in future research. The benefits of the use of a strong mixed methodology were demonstrated and examples of how this methodology strengthens research were given. The concepts under investigation have been explored, in so far as this study permits. Areas of concern and areas of interest have been identified. One of the most powerful points to come out of this research was the plea from Mary, to psychotherapy in general. This emphasises an important incumbent duty, on all supervisors, organisations and associations, to offer support to their supervisees and members, and to let them know that it is okay to not be okay, that such conditions are transient and treatable, and that this too shall pass.
Bibliography


### Appendix A – Snapshot electronic questionnaire

#### Demographics

1. **What is your gender?**
   - [ ] Female
   - [ ] Male

2. **Which of the following best describes your current relationship status?**
   - [ ] Married
   - [ ] Widowed
   - [ ] Divorced
   - [ ] Separated
   - [ ] Single, but cohabiting with a significant other
   - [ ] Single, never married

3. **What is your age?**
   - [ ] 25 to 34
   - [ ] 35 to 44
   - [ ] 45 to 54
   - [ ] 55 to 64
   - [ ] 65 to 74
   - [ ] 75 or older

4. **Level of academic qualifications? (Highest reached)**
   - [ ] Diploma
   - [ ] Higher Diploma
   - [ ] Degree
   - [ ] Masters
   - [ ] Doctorate

5. **Where do you practice psychotherapy from?**
   - [ ] Home
   - [ ] Own premises
   - [ ] Psychotherapy / Counselling Center
   - [ ] Organisation
* 6. Working primarily in?
   - Public sector
   - Private sector

* 7. Work status in Psychotherapy?
   - Full time
   - Part time

* 8. How many years are you accredited with IAHIP?

* 9. Amount of Client hours per month? (Average)

* 10. Amount of personal therapy hours per month? (Average)

* 11. Amount of Supervision hours per month? (Average)

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**Stress v's Satisfaction - Accredited IAHIP Psychotherapists**

**Demographics**

* 12. Type of client issues you deal with?
   - General (all issues)
   - Specialised (only specific issues)

13. If working in specialised area(s) only, please specify
* 14. What self-care strategies, if any, do you practice?

☐ Meditation
☐ Mindfulness
☐ Breathing exercises
☐ Physical exercise
☐ None
☐ Other (please specify)  

* 15. How many hours per month do you consistently devote to practicing self-care strategies?


* 16. Would you be willing to participate in a one hour, face to face, interview, on this topic?

17. If the answer to the above question is yes, please provide contact information, below

Name  

City/Town/County (please specify)  

Email Address  

Phone Number  

Stress v's Satisfaction - Accredited IAHIP Psychotherapists

The Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way. Although some of the questions are similar, there
are differences between them and you should treat each one as a separate question. The best approach is to answer each question fairly quickly. That is, don't try to count up the number of times you felt a particular way, but rather indicate the alternative that seems like a reasonable estimate.

* 18. In the last month, how often have you been upset because of something that happened unexpectedly?

☐ Never ☐ Almost never ☐ Sometimes ☐ Fairly often ☐ Very often

* 19. In the last month, how often have you felt that you were unable to control the important things in your life?

☐ Never ☐ Almost never ☐ Sometimes ☐ Fairly often ☐ Very often

* 20. In the last month, how often have you felt nervous and “stressed”?

☐ Never ☐ Almost never ☐ Sometimes ☐ Fairly often ☐ Very often

* 21. In the last month, how often have you felt confident about your ability to handle your personal problems?

☐ Never ☐ Almost never ☐ Sometimes ☐ Fairly often ☐ Very often

* 22. In the last month, how often have you felt that things were going your way?

☐ Never ☐ Almost never ☐ Sometimes ☐ Fairly often ☐ Very often

* 23. In the last month, how often have you found that you could not cope with all the things that you had to do?

☐ Never ☐ Almost never ☐ Sometimes ☐ Fairly often ☐ Very often
* 24. In the last month, how often have you been able to control irritations in your life?

☐ Never ☐ Almost never ☐ Sometimes ☐ Fairly often ☐ Very often

* 25. In the last month, how often have you felt that you were on top of things?

☐ Never ☐ Almost never ☐ Sometimes ☐ Fairly often ☐ Very often

* 26. In the last month, how often have you been angered because of things that were outside your control?

☐ Never ☐ Almost never ☐ Sometimes ☐ Fairly often ☐ Very often

* 27. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

☐ Never ☐ Almost never ☐ Sometimes ☐ Fairly often ☐ Very often

Stress v's Satisfaction - Accredited IAHIP Psychotherapists

PROFESSIONAL QUALITY OF LIFE SCALE

Helping people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. We would like to ask you questions about your
experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the last 30 days.

* 28. I am happy.

Never | Rarely | few times | Sometimes | Often | Very often

* 29. I am preoccupied with more than one person I help.

Never | Rarely | few times | Sometimes | Often | Very often

* 30. I get satisfaction from being able to help people.

Never | Rarely | few times | Sometimes | Often | Very often

* 31. I feel connected to others.

Never | Rarely | few times | Sometimes | Often | Very often

* 32. I jump or am startled by unexpected sounds.

Never | Rarely | few times | Sometimes | Often | Very often

* 33. I feel invigorated after working with those I help.

Never | Rarely | few times | Sometimes | Often | Very often

* 34. I find it difficult to separate my personal life from my life as a helper.
* 35. I am losing sleep over traumatic experiences of a person I help.

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

* 37. I feel trapped by my work as a helper.

* 38. Because of my helping, I have felt “on edge” about various things.

* 39. I like my work as a helper.

* 40. I feel depressed as a result of my work as a helper.

* 41. I feel as though I am experiencing the trauma of someone I have helped.
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<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Few times</th>
<th>Sometimes</th>
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* 42. I have beliefs that sustain me.

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<th>Sometimes</th>
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* 43. I am pleased with how I am able to keep up with helping techniques and protocols.

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<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Few times</th>
<th>Sometimes</th>
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* 44. I am the person I always wanted to be.

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<th>Few times</th>
<th>Sometimes</th>
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* 45. My work makes me feel satisfied.

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<th>Few times</th>
<th>Sometimes</th>
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* 46. Because of my work as a helper, I feel exhausted.

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<th>Sometimes</th>
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* 47. I have happy thoughts and feelings about those I help and how I could help them.

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<th>Few times</th>
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* 48. I feel overwhelmed because my casework load seems endless.

Never  Rarely  few times  Sometimes  Often  Very often

* 49. I believe I can make a difference through my work.

Never  Rarely  few times  Sometimes  Often  Very often

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

Never  Rarely  few times  Sometimes  Often  Very often

* 51. I am proud of what I can do to help.

Never  Rarely  few times  Sometimes  Often  Very often

* 52. As a result of my helping, I have intrusive, frightening thoughts.

Never  Rarely  few times  Sometimes  Often  Very often

* 53. I feel “bogged down” by the system.

Never  Rarely  few times  Sometimes  Often  Very often

* 54. I have thoughts that I am a “success” as a helper.

Never  Rarely  few times  Sometimes  Often  Very often
* 55. I can't recall important parts of my work with trauma victims.

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<th>Never</th>
<th>Rarely</th>
<th>Few times</th>
<th>Sometimes</th>
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* 56. I am a very caring person.

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<th>Few times</th>
<th>Sometimes</th>
<th>Often</th>
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* 57. I am happy that I chose to do this work.

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<th>Never</th>
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<th>Few times</th>
<th>Sometimes</th>
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Appendix B - Perceived Stress Scale (PSS-10)

Instructions:

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer each question fairly quickly. That is, don't try to count up the number of times you felt a particular way, but rather indicate the alternative that seems like a reasonable estimate.

For each question choose from the following alternatives:

0 = Never :  1=Almost Never :  2=Sometimes :  3=Fairly Often :  4=Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly?

2. In the last month, how often have you felt that you were unable to control the important things in your life?

3. In the last month, how often have you felt nervous and “stressed”?

4. In the last month, how often have you felt confident about your ability to handle your personal problems?

5. In the last month, how often have you felt that things were going your way?

6. In the last month, how often have you found that you could not cope with all the things that you had to do?

7. In the last month, how often have you been able to control irritations in your life?

8. In the last month, how often have you felt that you were on top of things?

9. In the last month, how often have you been angered because of things that were outside your control?

10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?
## Appendix C – ProQol - V

### Compassion Satisfaction and Compassion Fatigue

**ProQOL Version 5 (2009)**

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

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<tbody>
<tr>
<td>0=Never</td>
<td>1=Rarely</td>
<td>2=A Few Times</td>
<td>3=Sometimes</td>
<td>4=Often</td>
</tr>
<tr>
<td>1.</td>
<td>I am happy.</td>
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<td>2.</td>
<td>I am preoccupied with more than one person I help.</td>
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<td>3.</td>
<td>I get satisfaction from being able to help people.</td>
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<td>4.</td>
<td>I feel connected to others.</td>
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<td>5.</td>
<td>I jump or am startled by unexpected sounds.</td>
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<td>6.</td>
<td>I feel invigorated after working with those I help.</td>
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<td>7.</td>
<td>I find it difficult to separate my personal life from my life as a helper.</td>
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<td>8.</td>
<td>I am losing sleep over traumatic experiences of a person I help.</td>
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<td>9.</td>
<td>I think that I might have been affected by the traumatic stress of those I help.</td>
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<td>10.</td>
<td>I feel trapped by my work as a helper.</td>
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<td>11.</td>
<td>Because of my helping, I have felt “on edge” about various things.</td>
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<td>12.</td>
<td>I like my work as a helper.</td>
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<td>13.</td>
<td>I feel depressed as a result of my work as a helper.</td>
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<td>14.</td>
<td>I feel as though I am experiencing the trauma of someone I have helped.</td>
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<td>15.</td>
<td>I have beliefs that sustain me.</td>
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<td>16.</td>
<td>I am pleased with how I am able to keep up with helping techniques and protocols.</td>
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<td>17.</td>
<td>I am the person I always wanted to be.</td>
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<td>18.</td>
<td>My work makes me feel satisfied.</td>
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<td>19.</td>
<td>Because of my work as a helper, I feel exhausted.</td>
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<td>20.</td>
<td>I have happy thoughts and feelings about those I help and how I could help them.</td>
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<td>21.</td>
<td>I feel overwhelmed because my casework load seems endless.</td>
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<td>22.</td>
<td>I believe I can make a difference through my work.</td>
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<td>23.</td>
<td>I avoid certain activities or situations because they remind me of frightening experiences of the people I help.</td>
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<td>24.</td>
<td>I am proud of what I can do to help.</td>
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<td>25.</td>
<td>As a result of my helping, I have intrusive, frightening thoughts.</td>
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<td>26.</td>
<td>I feel “bogged down” by the system.</td>
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<td>27.</td>
<td>I have thoughts that I am a “success” as a helper.</td>
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<td>28.</td>
<td>I can't recall important parts of my work with trauma victims.</td>
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<td>29.</td>
<td>I am a very caring person.</td>
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<td>30.</td>
<td>I am happy that I chose to do this work.</td>
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Appendix D – Classified add I.A.H.I.P.

Dear Accredited IAHIP Therapist,

My name is Shane Gallagher. I am commencing my final year of a Masters in Psychotherapy. I am also a student member of IAHIP. As part of my final year I am required to complete a thesis. I have chosen to investigate the impact of stress and burnout v's compassion satisfaction, on accredited IAHIP psychotherapists. I have proposed to carry out both quantitative and qualitative research, using a demographic questionnaire, a stress scale, a quality of life scale and a small amount of follow up interviews. I am hoping that you and other accredited IAHIP therapists may be able to assist me, by following the link and completing the questionnaire it leads to. Obviously, the more members who respond, the more representative my results would be, to the population under examination. Participants will remain anonymous and no identifying information will be disclosed. Participation is of course voluntary and you may withdraw your participation at any time. Please click on the following link, for access to this questionnaire, which should take about seven minutes to complete:

https://www.surveymonkey.com/s/MZV257Q

Without participants, there would be no research and no findings, which add to and improve theory and practice. Accordingly, I would be very grateful for your participation in this research. Should anything be triggered in you, as a result of your participation in this research, please contact me directly (contact details provided, at end) if I can be of assistance, or bring to your own therapy. I enclose my contact details and am willing to address any queries or concerns, which you may have in relation to this matter.

Yours sincerely,

Shane Gallagher

shanegallagherace@gmail.com
Appendix E – Follow up e-mail request

Dear Accredited IAHIP Therapist,

My name is Shane Gallagher. I am commencing my final year of a Masters in Psychotherapy, at Dublin Business School, Aungier Street, Dublin 2. I am also a student associate of IAHIP. As part of my final year I am required to complete a thesis. I have chosen to investigate the impact of stress and burnout v’s compassion satisfaction, on accredited IAHIP psychotherapists. I have proposed to carry out both quantitative and qualitative research, using a demographic questionnaire, a stress scale, a quality of life scale and a small amount of follow up interviews. I am hoping that you and other accredited IAHIP therapists may be able to assist me, by following the link and completing the questionnaire it leads to. Obviously, the more members who respond, the more representative my results would be, to the population under examination. Participants will remain anonymous and no identifying information will be disclosed. Participation is of course voluntary and you may withdraw your participation at any time. Please click on the following link, for access to this questionnaire, which should take about seven minutes to complete:

https://www.surveymonkey.com/s/MZV257Q

Without participants, there would be no research and no findings, which add to and improve theory and practice. IAHIP has indicated that they may publish a synopsis of the outcome of this research, on their website, so the results, hopefully, will be available to you. Accordingly, I would be very grateful for your participation in this research. Should anything be triggered in you, as a result of your participation in this research, please contact me directly (contact details provided, at end) if I can be of assistance, or
bring to your own therapy. I enclose my contact details and am willing to address any queries or concerns, which you may have in relation to this matter.

P.S. If you are aware of any other accredited IAHIP psychotherapists who would be willing to participate in this research I would be grateful if you forwarded this e-mail to them.

Many thanks for your time and participation.

Yours sincerely,

Shane Gallagher

shanegallagherace@gmail.com
Appendix F – Information and consent forms for Interviewees

INFORMATION FORM

My name is Shane Gallagher and I am currently undertaking an MA in Psychotherapy, at Dublin Business School. I am inviting you to take part in my research project which is concerned with Compassion Fatigue v’s Compassion Satisfaction. I will be exploring the views of people like yourself who work as Integrative Psychotherapists.

What is involved?

You are invited to participate in this research along with a number of other people because you have been identified as being suitable, being an Integrative Psychotherapist. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an hour to complete. During this I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

DECLARATION

I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.

I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) ____________________________

Signature______________________________________________________

Date   /   /

CONSENT FORM

Protocol Title:
An exploration of Compassion Fatigue v’s Compassion Satisfaction

Please tick the appropriate answer.

I confirm that I have read and understood the Information Leaflet attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered.

☐ Yes ☐ No

I understand that my participation in this study is entirely voluntary and that I may withdraw at any time, without giving a reason.

☐ Yes ☐ No

I understand that my identity will remain confidential at all times.

☐ Yes ☐ No

I am aware of the potential risks of this research study.

☐ Yes ☐ No

I am aware that audio recordings will be made of sessions

☐ Yes ☐ No

I have been given a copy of the Information Leaflet and this Consent form for my records.

☐ Yes ☐ No

Participant: ___________________                  _______________________
                              Signature and dated                     Name in block capitals

To be completed by the Principal Investigator or his nominee.

I the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study, in a manner that he/she could understand. We have discussed the risks involved, and I have invited him/her to ask questions on any aspect of the study that concerns them.

________________                  ____________________                  ________
                               Signature                        Name in Block Capitals             Date
Appendix G – Questions for semi-structured interviews

1. So, what was your idea around becoming a Psychotherapist?

2. What would you say has supported you in this work?

3. What has been your greatest challenge in engaging in this work?

4. Can you tell me a little about your experience of the training process?

5. What do you think adds to your stress levels, in this work?


7. Do you think certain types of clients impact on you more than others? If so, how?

8. How much do you think about clients in between sessions?

9. How do you find your experience of being a psychotherapist now, as compared to when you qualified?

10. How do you find meaning in this work?

11. Lastly, have you anything you would like to add or talk about, in relation to this topic?
Appendix H – Qualitative process
106
Stress

- Personal
- Conflict
- Complex Clients
- Retro Stress
- Control - LOC
- Critic - Hard S. S.
- Isolation

Consequence Satisfactions

- Experience
- S. Developed
- Growth
- Satisfaction
- Confidence
- Self-Belief
- Negotiation
- Competence (OC)
- S. Comparison
- Privilege

Self-Care

- Awareness
- Life Balance
- Boundaries
- Client Balance
- S. Care Strats

Support

- Supervision
- Peer Support
- Soc -
Anne Clusters

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<tr>
<th>Stress</th>
<th>B/D</th>
<th>Core Satisfaction</th>
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<td>Conflict</td>
<td>B/D</td>
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<td>Complex deals</td>
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<td>Role Stress</td>
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<tr>
<td>Control FOX</td>
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<thead>
<tr>
<th>Components Satisfaction</th>
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<tbody>
<tr>
<td>Growth</td>
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<tr>
<td>Satisfaction</td>
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<td>Confidence</td>
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<td>Self Belief</td>
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<td>Negotiation</td>
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<td>Competence(KS)</td>
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<tr>
<th>Self-Care</th>
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<tr>
<td>Self Development</td>
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<td>Awareness</td>
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<tr>
<td>Supervision</td>
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<tr>
<td>Peer Therapy</td>
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<tr>
<td>Self Support</td>
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<tr>
<td>Sex</td>
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<tr>
<td>Life Balance</td>
</tr>
<tr>
<td>S-Care Stats</td>
</tr>
</tbody>
</table>
Combined Clusters - F.M.A

STRESS
- Life Stressors
- Conflict
- Complex clients
- Retro stress
- Control - F.O.C
- Gil-Hock S-Ego
- Isolation

B/OUT
- Work overload
- B/OUT
- Org stress
- S- would
- S.T.S

Self Development
- Companion Satisfaction
  - Experience
  - Growth
  - Satisfaction
  - Confidence
  - Self Belief
  - Reputation
  - Competency (UC)
  - S- Comparison
  - Credibility
  - Privilege
-

ORG Support
- Recognition/Validation
- Connection
- Secure Base

Trouble
- Secure Base

INTERNAL

EXTERNAL

Self Care
- Support
- Supervision
- Support
- Supervision
- Travel/Hobbies
- Client Balance
- Boundaries
- Care Staff

Life Balance
- Self Awareness
- Self Development
- 4C
- 3 Peer Support
- Soc 11
- 1 PMT
<table>
<thead>
<tr>
<th>Subordinate Themes</th>
<th>Superordinate Themes</th>
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<tbody>
<tr>
<td>Stress &amp; Compassion Fatigue</td>
<td>Stress</td>
</tr>
<tr>
<td>(i) Stress</td>
<td>(i) External Factors</td>
</tr>
<tr>
<td>(ii) Supervision</td>
<td>(ii) Support Structure</td>
</tr>
<tr>
<td>(iii) Burnout</td>
<td>(iii) Satisfaction Internal Factors</td>
</tr>
<tr>
<td>(iv) S.T.S.</td>
<td>(iv) Self-care Strategies</td>
</tr>
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Appendix I – Further extracts and reflection

Stress:

Control

PT.2 – 3(B) Mary: “….There's quite a few of us out there, so you can't be in a fair situation.” (you have no control)

Isolation

Isolation came up for two of the interviewees and was quite passionately stated:

PT.1 – 2(C) Fiona: “I would hate to work as a lone soldier or work from home and I would find that very, very empty.” (high emphasis on last three words)

PT.2 – 5(B) Mary: “…you can be a lone counsellor in an environment that's sympathetic, but not entirely knowledgeable about what it is that you do or what goes on…… that can be stressful and isolating if you feel that you're on your own.”(said with pain rather than anger).

Secondary traumatic stress:

PT.2 – 11(E) Mary: “Yes their family environment, their dynamics. There's no such thing as a perfect family. We all carry little traumas from that. So who else do I find difficult. Sometimes I find women who are a bit like me difficult of course. Middle class, well-heeled women, I’m not very good with.”
Mary also referenced the impact of counter-transference very well:

**PT.2 – 5(A)**  
*Mary:* “Obviously if you have a client who’s very disturbed or very entrenched then there can be, a kind of a bodily connection that’s impactful at times……”

Anne made direct reference to the part her own wound played in dealing with clients:

**PT.3 – 10(A)**  
*Anne:* “Yes to hear someone and to believe them, you know, not want to shut them down you know so yes. So it’s really about I suppose my, I suppose it maybe you know comes from my own, you know, unmet developmental needs,….”

**Reflection:**

Engaging in this research generated a form of parallel process. In the preceding five months to submission, sadly, I lost my father and a sister. Apart from the grieving process, this left my thesis in abeyance for a time. The return to working on it and impending timelines generated considerable stress. I also felt that immersion in the qualitative data generated stress, in its own right, some of this was due to triggers within the material (transference), but some was counter-transference related (Freud, 1912). Personal self-care strategies, including mindfulness, meditation, tai-chi, breathwork and physical exercise, were an essential aid to getting me through this process. While the stressors are acknowledged, there was also a sense of accomplishment (satisfaction) and a sense that this was not a permanent state (transience). However, if the above positives were removed from the equation, this process could have easily led to negative consequences. The irony being that this is the exact format of the processes which are being examined within this study.