An Exploration of Burnout in Improving Access to Psychological Therapy (IAPT) Services: An Interpretative Phenomenological Analysis

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ABSTRACT

Background: Improving Access to Psychological Therapies (IAPT) services are a provision of care characterised by high workloads and high turnover which can mean high levels of burnout. Within the IAPT workforce, research shows that two-thirds of Psychological Wellbeing Practitioners and half of the High-Intensity therapists, experience higher levels of emotional exhaustion, and depersonalization than seen within the mental health workforce. There are implications for the clients, therapists, and organisations where persons are affected by burnout.

Aims: The objective of this research was to explore participants' experiences of burnout and work-related stress in IAPT services which included the components of burnout, emotional exhaustion (EE), depersonalization (DP) and personal accomplishment (PA).

Method: Semi-structured interviews and interpretative phenomenological analysis (IPA) were used for data collection and analysis respectively, as they were the most appropriate for understanding individual's experiences from their own perspectives. Therapists from two IAPT teams in the South West were invited to participate.

Results: Analysis revealed three major themes: Therapist Wellbeing, Caseload Challenges and Organisational Support, each with subthemes. Participating therapists discussed their experiences of high caseloads and complex client presentations. They shared their experiences of emotional, mental and physical effects on their wellbeing and expressed the need for more space and time for reflection and supervision.

Conclusion: There are potential implications for maintaining the workforce. The insights shared by these ten individuals can contribute to an informed process of change that can help reduce the experience of burnout.

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Glossary

Maslach Burnout Inventory MBI	A measure designed to assess the existence and extent of burnout amongst staff working in human services.
Emotional Exhaustion EE	Refers to overwhelming exhaustion relating to the over- expenditure of emotional and physical resources.
Depersonalisation DP	Refers to feelings of cynicism that represent negative responses to diverse aspects of a job.
Personal Accomplishment PA	Refers to feelings of accomplishment relating to positive self-evaluations of one's job performance.
Improving Access To Psychological Therapies IAPT	A primary care mental health service.

Defining Terms used in the Study

Therapist

This refers to anyone providing therapy within IAPT, having been trained as a counsellor, cognitive behavioural psychotherapist, psychotherapist, assistant psychologist, psychological wellbeing practitioner, clinical or counselling psychologist. The specific title the therapists used to describe themselves is documented in the results section.

High Intensity Therapist/Cognitive Behavioural Therapist

These terms refer to therapists who work with clients using cognitive behavioural therapy (CBT), which is a solution-based therapy which explores the relationship between thoughts, emotions, physical sensations and behaviours. The terms are interchangeable, however High Intensity (HI) is a term which came about as part of the IAPT system, noting the difference between-low intensity therapy (6 sessions) of guided self-help and high intensity therapy (12-18 sessions).

Psychological Wellbeing Practitioner (PWP)

This role refers to therapists who offer low intensity CBT (6 session) short term therapy. PWP's offer assessment and treatment.

Assistant Psychologist

This role was identical to that of a PWP however these individuals would not have undertaken the IAPT PWP training which is a 9-month university program. They would have learnt the role through in-house training and supervision.

Counsellor

These therapists offer person centred or relational therapy which is focused on reflection rather than problem solving.

Psychology Practitioner

This is an eclectic term which several individuals used to describe individuals who offered both counselling and CBT. It also appeared to be a term used by therapists of any orientation who wished to share a more inclusive title with colleagues.

Therapeutic Relationship

This refers to the relationship between the therapist and the client. In counselling psychology, this is viewed as the foundation of therapy. Its benefits are well documented in the literature for example Horvath and Simmons (1991).

Patient/Client

These terms are used interchangeably to refer to individuals who are in undertaking psychological treatment from any therapist.

Introduction

This thesis qualitatively explores the experiences of burnout of ten therapists working in an Improving Access to Psychological Therapies (IAPT), primary care mental health services in the South of England. Due to the relatively recent development of the IAPT program in 2008, there is a scarcity of research into IAPT. There are very few studies on the workforce and their welfare.

Work related stress is widely referred to as *burnout.* Working in mental health services often means that individuals regularly listen to traumatic experiences as part of their therapeutic role. Persons in such roles often experience a reduction in compassion and are more vulnerable to *burnout*.

Burnout

Burnout, as a construct has been described as emotional, physical and mental exhaustion (Pines & Aronson, 1988). Burnout was first recognised as a psychological syndrome in the 1970s, almost simultaneously by a psychiatrist conducting clinical work (Freudenberger, 1974) and by a social psychology researcher (Maslach, 1976).

With the recognition of various definitions of phenomena similar to burnout including terms such as compassion fatigue, vicarious traumatisation, and secondary traumatic stress, this study recognises these definitions and terms and the thesis will present an exploration of burnout holding the Maslach definition in mind.

A review of literature, using various relevant terms (e.g. wellbeing, burnout, work related stress) showed that burnout was the most researched and evidenced as such it was chosen to underpin the thesis. While being well researched there was no existing in-depth qualitative analysis on burnout among IAPT therapists.

The Maslach Burnout Inventory provides a widely used measure of burnout and has aided in the development of a strong body of research in the area. Maslach's definition contained three core components of burnout as emotional exhaustion (EE), depersonalisation (DP) and personal accomplishment (PA) (Maslach, Jackson & Leiter (1996). Emotional exhaustion involves overextending emotions to a point of exhaustion. It drains individuals emotionally and mentally and therefore impacts on how they interact with patients. Depersonalization is similar to cynicism, or disengagement which is an impersonal indifference and lack of empathy for client's treatment and care. Personal accomplishment encompasses feelings of efficacy and success with one's work. In the next section, relevant research on burnout will be discussed before narrowing the focus to IAPT related research.

Research on Burnout

Emotional exhaustion can be related to working long hours, the time spent doing administrative work (such as writing up notes after seeing clients), higher incidents of lack of self-care and lack of autonomy (Rupert & Morgan, 2005). Emotional exhaustion was related to higher job demands and personal accomplishment showed a significant correlation to independent decision-making (Evans, Huxley et al., 2006). Their study was conducted using participants who were mental health social workers. Emotional exhaustion, depersonalization and personal accomplishment are increased by different work-related factors and job stressors (Evans et al., 2006). Depersonalization showed strong correlations with over-involvement with clients, challenging client behaviours and was inversely correlated with perceived autonomy. Personal accomplishment was positively correlated to the number of therapy hours conducted, the percentage of self-pay clients, and perceived control within the work setting and inversely related to the time spent on testing and administrative and paperwork tasks (Rupert et al., 2005). From the studies discussed earlier, it is evident that some persons can experience burnout but not be significantly negatively impacted by each component. Thus, while these three

components are linked to the burnout syndrome and have strong influences on each other they can also be independent of each other. Indeed, this interdependent relationship between components would be worth exploring in greater detail to understand therapists' perspectives regarding how these components interact with them and how they may affect relationships and attachments with clients.

Burnout and Therapists

Research indicates that therapists are at high risk of burnout (Freudenberger, 1975; Maslach, 1976; Maslach & Jackson 1981). Maslach's original study of burnout examined why persons who experienced emotional arousal on the job might become detached or engage in self-defence mechanisms of dehumanization. While there was anecdotal evidence of burnout prior to Maslach's (1993) and Faber's (1983) investigation into the phenomenon, it was not until their research in the 1970's that the term burnout came into common usage in the mental health field and the phenomenon became more researched. Faber (1983) suggested that two trends left individuals more susceptible to burnout, firstly they became withdrawn from their communities and secondly more reliant on their work for fulfilment.

Any discussion of burnout inevitably touches on the phenomenon of stress, which many consider to be a similar process. Selye (1967) is the founding father of '*stress*' research. Stress may contribute to burnout and is a precursor or vulnerability to burnout (Maslach, Schaufeli, & Leiter, 2001; Pines *et al*., 1981, Pines & Aronson, 1988). It has been argued that the distinction between burnout and stress can only be made retrospectively (Selye, 1967). On one hand, stress occurs where the individual's adaptation process has occurred successfully with task completion, and on the other hand, burnout refers to a breakdown in that adaptation process (Seyle, 1967). Burnout is the observable symptoms of an employee who perceives the demands and expectations of the workplace as outweighing what he/she is able to do and loses motivation and effectiveness within their role (Cherniss, 1980). The clinical term *burnout* was

evolving as early as 1969, Bradley (1969) applied it to those who worked as helping professionals, in this instance probation workers and it has now become representative of a psychological phenomenon.

Burnout develops over time when individuals enter a job, expect clear achievable goals, supervision of, and recognition for, the work done, however, if these expectations are not met then employees gradually become more disenchanted and either leaves or experience distress. Burnout is therefore based on the relationship that people have with their work. If exhaustion occurs not everyone is affected in the same way. How people respond to the relationship with their work consciously or unconsciously can result in burnout (Maslach et al., 2001), and this is further mediated by their environmental factors. The temporal element of burnout suggests burnout is a process, therefore a major downfall of burnout research is that it is often being measured as a state rather than a process. An implication of this is that more longitudinal research is needed in this area, as this would offer more insights into the stages of the burnout process and can lead to testing of interventions that could be focused on prevention rather than reaction. In the next section, existing literature relevant to the research will be reviewed.

Literature Review

This literature review will explore some of the existing research on burnout among mental health professionals. It seeks to highlight early research into the phenomenon and will give the reader a sense of the concept of burnout and relating this to the present Improving Access to Psychological therapist (IAPT) system. This review will not discuss all current literature on burnout but will identify those studies that are most relevant to mental health and IAPT.

Burnout among Mental health professionals

Since Freudenberg first coined the term '*burnout*' there has been growing interest in research on burnout and its relationship to turnover, absenteeism, and physical and psychological impact on staff (Paris & Hodge, 2010). Notably, burnout is associated with negative impact on patient care and may lead to increased cost associated with sick pay and recruitment (Garland, 2002; Maslach, 1993). There is limited research on the impact of burnout on clients (Gardner, 2006).

Due to the negative impact of burnout, several measurements have been developed to determine levels of burnout in staff such as Staff Burnout Scale for Health Professionals (Jones, 1980), the Burnout Measure, (Pines & Aaronson, 1988) and the Maslach Burnout Inventory (Maslach *et al*.,1996). The Maslach Burnout Inventory (MBI) has been widely used and is considered to be a gold standard by many researchers (e.g Schutte, Toppinen & Kalimo, 2000). As the individual components of this MBI will be relevant to the qualitative nature of the study being proposed I have outlined them in the introduction.

However, scoring highly overall on the Maslach Burnout Inventory (MBI) does not mean that the individual has scored highly on each component, they maybe more affected by one or two areas. A national study in the United Kingdom conducted by the Sainsburys Centre for Mental Health (1993) explored the level of burnout among mental health workers (Oynett,

Heppleston & Bushnell 1994; Oynett, Pillinger & Mujen 1995). Using 445 participants, 44% scored in the high range for burnout using the MBI. Despite overall high scores on the MBI, it was noted that the component score for depersonalization (DP) or detachment from clients did not show high scores. This indicated that burnout does not necessarily lead to a high score depersonalization, however scoring highly on the emotional exhaustion (EE) component appears to show high correlation with the overall burnout score.

Much of the research on burnout to date has been quantitative in nature: Paris *et al.* (2010) presented a review of '*Burnout in the Mental Health Workforce*' and reviewed 145 articles from 1990 to 2009. The paper focused on strengths and weaknesses of methodological reports. The Paris et al. (2010) review of studies on burnout suggested that much of the research conducted in this field was methodologically weak, as studies often relied on casual observation, anecdotes or informal surveys. In a systematic review of 145 studies of burnout among health care staff in the US and UK, Paris et al. (2010) concluded that there were high levels of burnout among staff working in mental health sectors and suggested that there should be more research into high levels of distress for staff working in this sector. All of the research above indicated high levels of emotional exhaustion. With this in mind a qualitative exploration can potentially give more insight into this issue of burnout in therapists and explore how it is experienced in relation to the subcomponent: emotional exhaustion.

Organizational Factors contributing to burnout

While various components can impact on therapists' experience of burnout, this section will focus on the organisational influences. There was a highly significant correlation between caseload and stress (Hellman, Morrison, and Abramowitz, 1986). Therapists may experience emotional exhaustion (defined as a symptom of burnout by Maslach and Jackson, 1981), as a result of feeling responsible for the clients on their caseload even when they are not at work, resulting in them feeling overwhelmed (Reid et al. (1999). In evaluating this research, it is

evident that the greater their caseload, then the more likely therapists are to experience personal and professional factors relating to burnout. Therefore, it may appear that stress is institutionalized within IAPT as the Psychological Wellbeing Practitioner role has been considered to be '*low intensity-high volume'* (Department of Health: DOH, 2008). It follows that exploration of how their caseload impacts on their experience of burnout is imperative for therapist wellbeing and consequently the wellbeing of their clients. This will be addressed in the present research.

Arguably, independent therapists, who do not work within the IAPT model, appear to experience less burnout than those who work in organisations such as IAPT where such high-volume work is institutionalised (Ackerley, Burnell, Holder, & Kurdek, 1988; Farber, 1985). This may be because independent practitioners have more autonomy, hence more influence over possible organizational factors that are associated with burnout. Independent mental health practitioners can adapt their caseloads, policies, working hours around their needs and this can lead to less emotional exhaustion and burnout. Work environments where there are high levels of emotions can lead to chronic stress and burnout (Maslach and Jackson, 1996). Perhaps, in high stress environments (such as IAPT), if burnout is to be avoided then it is important to focus on supporting staff, giving them more autonomy, attending to individual factors (Maslach & Leiter, 2008).

Individual factors and burnout

While the importance of organisational factors cannot be overemphasized, there are also significant individual factors that contribute to burnout. Practitioners in emotion-focused work such as therapy can of course experience burnout, however individual factors such as coping strategies, personal stress and resilience can mediate the degree to which it manifests for the individual (Paine, 1982). Several factors that can increase therapists' susceptibility to burnout are: dilution of personal resources, pressures inherent in the therapeutic relationship; work over

involvement (such as going beyond their therapy roles to assist clients), work condition; stressful client behaviours, and passivity of therapeutic work (Ackerley et al., 1988).

Another individual characteristic that impacts burnout is resilience. Resilience refers to those personal qualities that help individuals to thrive despite the experience of adversity (Connor & Davidson, 2003). Challenges in the workplace have been thought to help develop professional resilience and in turn, this is sustained by a strong professional identity.

Coping strategies are a significant part of resilience and burnout. Adaptive coping strategies are the individual's abilities to manage adversity and had been linked to better physical and mental health (Buchanan & Keats, 2011). Interventions to build this include physical exercise, rest, relaxation, good nutrition, moderate alcohol use and non-smoking lifestyle (de Terte, Stephens & Huddleston, 2014). Social support also affects physical and mental health. Usually, this support comes from families and friends (Reis & Collings, 2000) and work systems and colleagues (Woods, 2005). Resilience can also be built by adapting the expectations that practitioners and organisations carry, therefore this individual factor can be strongly influenced by the organisational environment. Due to the emotional resources that are necessary for the role, there needs to be systemic and individual self-compassion and consideration of self-care offered to the therapist, to help them give the warmth and empathy needed in a therapeutic relationship.

Research by Forrest, Elman, Gizara and Vacha-Hasse, (1999) and Schoener (1999) suggested that therapists are often likely not to apply the type of therapy they offer, to their own lives. This is further supported in IAPT based research by McAuley (2010) which found that 20.4% of trainees in the IAPT course they sampled reported not using rational or cognitive coping skills despite it being their main area of training.

Impact of burnout on the individual

Burnout is associated with personal distress, physical exhaustion, marital and family problems and drug and alcohol use (Maslach & Jackson, 1981). Rupert and Morgan (2005) highlighted various negative consequences of burnout such as lower quality work, spending more time on administrative tasks, negative self-evaluations and possibly higher levels of staff turnover. More recently, Fleischmann, Carr, Stanfeld, Xue and Head (2018) provided a 20 year follow up on the Whitehall II study. This suggested that chronic disease increased the risk of work exit for this cohort especially the risk related to health-related exits. Social support mediated the risk of health-related exit and unemployment. Additionally, Madsen et al. (2017) conducted a systematic review and meta-analysis which evidenced that perceived job strain increases the likelihood of risk of clinical depression.

Job performance, individual health issues and strong links to substance abuse have been well documented among mental health workers (Cherniss, 1980; Cherniss, 1995; Kalimo, El-Batawi, & Cooper, 1987). People who work in close proximity to the individual who experiences burnout may be negatively affected and this leads to job task disruptions. Maslach, et al. (2001) have viewed burnout as contagious and other researchers have highlighted that it can lead to '*staff infection'*, meaning that people around the individuals affected by burnout begin to exhibit similar symptoms (Edelwich & Brodsky, 1980).

Burnout has been implicated in negatively affecting the client's perceptions of the service provider or therapist. In other health care areas, GPs have been found to have given incorrect diagnoses and care when experiencing burnout (Zaslove, 2001). Among radiologists it has been shown that burnout has a direct impact on their work by reducing empathy for their patients (Sciacchitano, Goldstein & DiPlacido, 2001). While this study was conducted in the US it is relevant to similar roles in the UK. McCarthy and Frieze (1999) carried out similar research with psychotherapists and found that if the therapist displayed symptoms of burnout, then the

clients were less satisfied with their own individual therapy. This was due to the types of strategies therapists employed in their practice; these strategies were divided into personal and expert coerciveness methods. The latter was viewed as more beneficial by clients and the study found a high correlation of personal coerciveness methods by therapists who scored highly on the MBI.

Farber's (1983) research showed that while just over 19% of the therapists in his study scored highly on the measurement used to assess burnout, only two percent of them reported feeling emotionally distressed by their work and another two percent felt negatively impacted by working with people. A critique of this is that it that there may be more to burnout than a quantity measure can show and thus insight into therapists' experience through qualitative approaches will be beneficial. Farber and Heifetz (1982) interviewed sixty therapists in an attempt to determine what factors contributed to their experiences of burnout within therapeutic practice. Their research found that factors such as lack of therapeutic success, the non-reciprocal nature of the relationship (whereby the therapist offered attentiveness and held responsibility) influenced therapists' feelings of burnout. Factors such as overwork, the slow pace of the therapeutic process, the nature of the patient's problems and isolation were also found to be possible negative factors. While this study was published in 1982, recent research by Steel, McDonald, Schroder, & Mellor-Clark (2015) suggested similar findings in their more recent study of therapists (this study will be further discussed in the literature review). Drawing on the literature, it would be important in this study to explore if some of these factors are likely to be present for therapists in IAPT services.

Farber (1983) highlights that inexperienced therapists are less equipped to deal with patient difficulties and are hence more vulnerable to burnout. One possible cause of this occurs when therapists become frustrated with the variability of success in therapeutic work and try to work even harder to achieve the desired response, including thinking about patients outside

of work, which can be emotionally draining. This might be more common in inexperienced therapists who Farber (1983) describes as having '*more than a healthy bit of narcissism*' (p.9), i.e. an unfamiliarity of the limitations of therapy. Farber (1983) explains that for those who do not experience burnout, they may experience personal growth in their therapeutic work or an increase in their resilience. He also suggested that having contact with colleagues acts as a buffer and prevention from burnout. Farber's interviews explored the impact burnout had on therapists' work with clients. This included caring less about clients, frustration with patient's lack of progress, losing confidence in their own skills and feeling disillusioned.

There are two groups which experience burnout (Freudenberger, 1974). The first group becomes increasingly frantic and refuses to accept that their initial aims are unachievable, so they work extra hard to try and achieve them until they reach a breaking point. They neglect their personal lives for the hope of professional success. The second group can be seen as worn out, they have not internalized the success or lack thereof as representative of themselves, so they view obstacles as oppressive and so lack motivation. This idea of the impact of burnout is supported by Maslach, a social psychologist who observed how people in stressful jobs attempted to cope with the occupational demands. Some utilized a defence mechanism of detachment or dehumanizing the client (Maslach *et al*., 2001). In a similar fashion to Fredenberger Maslach conducted interviews using a sample of health care workers which included physicians, nurses, psychiatrists, and hospice counsellors. From this qualitative approach, she noticed three main responses: feelings of emotional exhaustion; negative perceptions and feelings towards their clients; and some felt emotional turmoil which resulted in a professional crisis and feeling that perhaps they were not good at their jobs (Maslach et al., 2001).

In summary, there are several individual and organizational factors that determine if stressful situations result in burnout for a therapist. There is a detrimental impact on the client,

the therapist, service and mental health system when burnout is present, thus it is an important area of concern. As I have discussed research on burnout in various mental health areas I will now describe the IAPT system to bring this research into a context that will be explored in the present research.

Critical evaluation of IAPT

In addition to the studies described above, burnout can impact on other mental health services such as Improving Access to Psychological Therapies (IAPT), which will be described in this section. IAPT was inspired by the findings of economist Richard Layard (The Centre for Economic Performance: CEP, 2006). Layard's report highlighted the economic cost of mental ill-health in the United Kingdom. Due to poor mental health a significant number of people of working age were on benefits or not making economic contributions to the state. This was due to the effects of mental health conditions, which could be addressed with psychological interventions if these were more accessible. The results from Layard's paper indicated that a mental health programme that addressed common mental health problems such as depression and anxiety would be economically self-sufficient, and it could lead to many patients returning to the workforce (Department of Health: DoH,2008a, 2012). A change in mental health was needed as there were long waiting lists for services and only the most severely affected persons where offered treatment. In many ways, IAPT, an advancement in primary care mental health services, was desperately needed within the National Health Service to meet the demand for psychological therapy. IAPT would be more accessible than existing mental health services as two hundred and fifty services would be set up and therapists could see patients at the local GPs, health centres and community-based sites. Layard (CEP, 2006) proposed that ten thousand therapists would be trained in cognitive behavioural therapy (CBT) with services

being able to offer National Institute for Health and Clinical Excellence (NICE) (2009) guideline approved treatment.

The IAPT program was piloted on two sites and had a success rate of over 50% (Clark, Layard, Smithies, Richards, Suckling, & Wright, 2009). IAPT was setup up using a stepped care model to offer treatment to people experiencing depression and anxiety (DOH; 2008b). Patients who entered the service were seen for an initial assessment by a step two worker or Psychological Wellbeing Practitioner (PWP). If the patient was suitable they would be offered six to eight sessions of low intensity CBT. This would be in the form of guided self-help and each session was expected to last an average of thirty to forty-five minutes. If the patient required more intensive support they would be offered treatment at step three by a High Intensity CBT therapist, a Counsellor, an Eye Movement Desensitization and Reprocessing (EMDR) therapist or an Interpersonal Therapist. Step three therapists provide hourly- weekly sessions for up to eighteen weeks.

Arguably, front line staff, specifically those who assess clients via self-referrals, (anyone walking into the service), are most at risk of developing burnout as they often lack the space for reflection, which can in turn impact on their ability to empathise with their clients. For instance, 'link-workers' (whose roles are similar in nature to that of IAPT Psychological Wellbeing Practitioners) were found to be more at risk of burnout, to work less effectively, and to have a negative perception of workplace stress (Bowden, Smith, Parker & Boxall, 2014). Some IAPT services in Bristol are moving from the Least Intervention First (LIFT) model to offering the clients the best/right intervention first, i.e. rather than receiving low intensity CBT first some clients are offered high intensity CBT initially if there is a rationale for this based on the severity of mental health difficulties.

There has been much controversy surrounding IAPT (Asare & O'Sullivan, 2010) and since the pilot centres at the beginning of IAPT's inception has been no systematic evaluation of empirical findings (Robins, 2014). Robins (2014) highlights that only 60% of clients who access IAPT complete a course of treatment this would mean that 40% drop out, thus raising the question about why so many leave therapy, and how this can be addressed. These statistics seem pertinent to the therapists themselves who may experience burnout as they try to help large numbers of clients, but almost half of their efforts are unsuccessful. It would be interesting to explore the impact that attrition and the lack of success may have on them and this information may arise from the interviews as personal accomplishment and feelings about work are discussed. Cooper (2009) argued that the theoretical basis for IAPT working towards an economic goal of reduced access to NHS resources, like GP appointments and in-patient care can cause in internal conflict for therapists whose goal is focused on the patient rather than the economics behind public health provision.

The British Psychoanalytic council and UK Council for Psychotherapy recently produced a report '*Addressing the deterioration of public psychotherapy provision'* (BPC & UKCP, 2015). The foreword gave an analogy of a cancer patient who would be asked to endure long waiting lists and be discharged after sessions even if they had not recovered. It invited the reader to note that the treatment that is seen as acceptable for mental health would not be considered sufficient for someone with a physical health problem. This impacts not only on patients but may also impact on the therapists who were unable to give the patients more sessions which, in their therapeutic judgement, the client would have found beneficial. This six-session treatment is part of the IAPT way of working for many teams; patients are offered six sessions of CBT and in many services, if CBT is not suitable for them and they are not eligible for high intensity CBT, there is a likelihood they will be signposted to private therapists and discharged. Many therapists are aware that clients have stated that they are unable to fund

their therapy privately and there may not be any charitable services that offer therapy in the area. This can lead to stress and internal conflict for the therapist. It is important that as part of the growth and development of IAPT that a range of choice can be offered to clients rather than a strong focus on CBT in a recent study Cooper, Wild, van Rijn, Ward and McLeod (2015) evidenced that pluralistic therapy for depression produced comparable reliable recovery rates or positive outcomes to existing IAPT statistics (Gyani, Shafran, Layard & Clark, 2013). With this in mind, IAPT services can increase the availability of pluralistic therapy and other interventions as part of improving access to a range of therapies rather than limiting patient choice to CBT.

Studies on IAPT

Research into staff burnout within the IAPT program is still in the early stages. One of the few studies to date that has explored the role of burnout on IAPT therapists was carried out by Steel et al. (2015) who explored burnout in eight IAPT services in the United Kingdom. Steel et al. (2015) presented a two-fold research method, the first null hypothesis being that therapists would not experience as high levels of burnout in IAPT as in other mental health professionals (determined by a comparison group) and secondly therapists' emotional involvement in their work would not account for variance in burnout that is not already explained by demographic differences. Three factors of burnout: Emotional Exhaustion (EE), Depersonalisation (DP) and Personal Accomplishment (PA) among IAPT therapists were explored. The results from 116 therapists showed comparatively high levels of EE and relatively low levels of DP and PA. The study noted that therapists who had stressful involvement with patients and particularly in-session feelings of anxiety exhibited EE and DP. Therapists who had successful treatment with clients exhibited higher Personal Accomplishment scores on the MBI. The most important predictors of therapist burnout were service-related, particularly work demands and lack of autonomy, and therapists' in-session

feelings. The study recommended that addressing these factors may help prevent burnout in IAPT services. Their study, although very interesting, leaves some areas unexplored such as the relationship between the different components of burnout. It follows that the rationale for the present research being proposed which is a qualitative approach to burnout will provide in depth data and perspectives of the therapists. It will explore how emotional exhaustion manifest and how this may be different from manifestations of PA or DP. It can be argued that this current research would make an original contribution to an identified gap in research.

An early pioneer researcher into IAPT Dr Rosemary Rizq has written several papers (with various co-researchers) in this area since IAPT's inception (e.g. Rizq 2013, 2014a). Rizq (2011, p. 52) expressed a psychoanalytic view of IAPT stating that therapists were ambassadors to:

> '*a split-off affective aspect of IAPT primary care mental health services, and that as such they will urgently need to ensure they do not succumb to burnout or unhelpful ways of working and relating within the team*.'

Rizq (2011) explains that as IAPT has been born out of a need for holding the anxieties of the nation and encouraging people to return to work, it is a bit out of place within existing mental health teams. This juxtaposition between the position of those in the health care profession with a mandate of helping others and the economic, target focused position of IAPT, echoes concerns earlier discussed in the literature review by the BPS (2016). Rizq's research suggests that within the mental health workforce there is concern about IAPT trained staff and their ability to work with the population. While her research looked at the broader organisational issues and was not specifically focused on burnout, there is nevertheless a clear indication that burnout is indeed a valuable avenue to explore in IAPT focused research. Rizq suggests that psychological therapists in IAPT were becoming at risk of burnout and vulnerable to stress and employee attrition.

Rizq's (2012b) publication '*The Ghost in the Machine: IAPT and Organizational Melancholia'* has crafted a view that the NHS was the sole entity and container for a nation's anxieties, frailties and insanity. She approached this from a psychoanalytic, political and cultural view and then focuses on the melancholia and psychological impact for all who are touched by it. Rizq (2012b) argued that the transparent agenda of IAPT and its target and outcome focused culture takes away therapeutic alliance in that it becomes less prioritized in the therapeutic consultation. She expressed an idea that when the unconscious discomfort in practitioners and service users alike arises, it is suppressed to maintain the status quo.

A case study of a Psychological Wellbeing Practitioner (PWP) who had a difficult assessment with an irate patient was presented in Rizq (2012a). Rizq discussed the PWP training and how this conflicted with the reality of therapists' experience and needs of the patient (Rizq, 2012a). Maslach, *et al.*, (1996) and Schaufeli & Enzmann (1998) argued that occupational factors that influence burnout are 'job overload'- the idea that the goal set out is unattainable, and role conflict and ambiguity. All of these are evident in the case study whereby the PWP feels their training and resources are inadequate to meet the patients' needs. The case study added inspiration for this current research as the article highlighted many difficulties in the structure of IAPT, decisions made based on activity targets or outcome measures. The case gives a snapshot of how this has affected the practitioner and led to feelings of inadequacy and how those emotions were processed. As this case study represents one individual an IPA study can offer the opportunity for in-depth analysis of the experiences of PWPs and other therapists within this current study. Rizq (2012a, p. 15) stated that '*if unaddressed this may lead to a deadening of life within services, where staff turnover, burnout and cynicism are likely to prevail'*. The preceding quote advances my argument which is supported by Rizq (2012a) that burnout and its impact on the therapist, the organization and the service users needs to be explored further.

Recently one unpublished doctoral thesis project relating to stress in IAPT has emerged. McAuley (2010) explored occupational stress or burnout and hardiness traits in IAPT Trainees. It explored sources of stress and strain for trainees and the interaction between these and the individual's coping resources. The study identified a few core areas that impacted on levels of stress; the boundaries of the roles, physical strain and access to social support. The study evidenced significantly higher levels of stress for males than females but no age-related differences. Control and commitment (to staying in the role) aspects of hardiness were found to be negatively correlated with stress. This paper was methodologically strong, the quantitative approach was well suited to the aims of that study and there was a 73% response rate, which compares favourably to similar research focused on mental health professionals. The limitations of the study were a low sample size (n=44) and the limited demographic information gathered which could have offered deeper insight into the analysis, for example how previous clinical experience impacts on perceived stress. Additionally, the study did not consider how organisational factors influenced experiences of occupational stress and this has been considered in this study. Placing this current study in the context of this slowly emerging research area, McAudely suggests that further research into the IAPT therapists is needed. It can be argued that the next recommended research from such a study would be a qualitative paper, such as this current study to gain more in depth understanding of the experiences of therapists in IAPT, and this was suggested in the limitations.

More recently in February 2016, the findings from wellbeing surveys conducted by the British Psychological Society and New Savoy in 2014 and 2015 were published. This showed that 46% of psychological professionals (which included IAPT therapists) reported depression. Just under half (49.5%) of the 1,300 plus therapists reported feeling like a failure, and 25 % stated they were affected by a long-term condition. Significantly 70% stated that they were finding their jobs stressful in 2015, demonstrating a 12% increase in one year. The results

showed 90% having a negative opinion about the nature of the services, stating that the target focused environments were a significant stressor and that resignation was an active consideration. Bullying and harassment reflected a significant increase. The findings of this survey contributed to the British Psychological Society charter for wellbeing and resilience of psychological staff, which states that the aim to '*improve access to psychological therapies'* (Pg 1.) can balance with more focus on staff wellbeing and sustainable services.

Almost 30% of IAPT staff reported having mental health problems, in a study on stress and coping in IAPT staff (Walklet & Percy, 2014). The research was a mixed method study, the quantitative measures of stress (GHQ-12) (Goldberg & Williams, 1988) and coping styles (COPE) (Carver, Scheier & Weintraub, 1989). were administered to 40 participants. Six staff members were interviewed, the data analysed using thematic analysis. The findings suggested that stress was prevalent for IAPT staff. Participants experienced difficulties that were not previously discussed in extant research such as a target focused environment and high stakes training, which meant if they failed their training courses they would also lose their jobs. The results of this study were limited by the small sample size and the single site recruitment strategy. However, the exploratory nature of the study has contributed to an understanding of difficulties within IAPT services, and as previously discussed there is a strong link between stress and burnout.

Research Rationale, aims and question

Rationale for this research and Contribution of knowledge to the field

There is strong evidence that burnout affects therapists thus impacting on the client's welfare and in turn wider health care system. As such, burnout is an important aspect to investigate in the public health sector. Despite a rich catalogue of research on burnout, some of which focuses on mental health professionals, the rationale for this research was inspired by the development of the IAPT services and the, as yet, small amount of research in this area.

The decision to conduct research on the effects of burnout within IAPT practitioners specifically is informed by the research discussed above and the researcher's own experiences of working in IAPT services. Firstly, a lot of research has been conducted on burnout affecting mental health workers in general and included psychiatrists, psychologists, social workers and other mental health workers. Secondly, the evidence (discussed within the literature review) shows that individual and organisational factors affect the likelihood of burnout, for example, high caseloads and lack of autonomy both contribute to burnout. These factors are part of the foundation of IAPT: PWP's are classed as '*high-volume workers*' (Rizq, 2012a); assessments are manualized (Rizq, 2012a); and recent research (Steel *et al.*, 2015) showed high levels of emotional exhaustion in IAPT workers. Therefore, it follows that an Interpretative Phenomenological Analysis research project exploring how emotional exhaustion, personal accomplishment, and depersonalisation are experienced by therapists and how it affects their wellbeing and their therapeutic relationships would be an important area of exploration for research in counselling psychology. Furthermore, Rizq (2012a) has stated IAPT as undoubtedly the biggest change in the mental health system in the UK and this research hopes to keep up with such changes by exploring IAPT services rather than mental health services overall.

Relevance

This study is relevant to the counselling psychology profession as mental health in the UK is changing and many counselling psychologists work in IAPT services. Psychologists regularly manage and supervise PWP's and High Intensity therapists, therefore, insight into this phenomenon will be beneficial. Counselling psychologist could have participated in the research as many work as therapists in IAPT under titles such as cognitive therapist or counsellors. Counselling psychologists are encouraged to be reflective and increasingly aware of the therapeutic process and attaching meaning to their experience thus it is hoped this

research will contribute to the understanding of process issues which are influenced by therapists' experiences of burnout and this is therefore relevant to the therapeutic relationship. It has been widely accepted, within counselling psychology, that the therapeutic relationship is the main focus of clinical practice (Horvath & Symonds, 1991; Martin, Garske & Davis, 2000; Woskett, 1999). This research will explore therapists' experience of burnout and how it affects the therapeutic relationship and the therapeutic work.

Counselling psychology has origins in phenomenological, existential and humanistic thinking that argued for the need to consider human beings in a holistic manner, emphasising a search for meaning and understanding (Woolfe, Dryden & Strawbridge, 2003) hence the use of IPA to explore therapists' experience of burnout is fitting. IPA has been used widely in various sections of psychology such as counselling, clinical, education and health psychology (Smith, Flowers & Larkin, 2009).

The primary research question was: how did therapists understand their experience and perceptions of burnout in the workplace? In examining therapists' experience, I explored a number of related issues, this included, the personal impact of burnout on therapists, their understanding of the impact of burnout on the therapeutic relationship and their experiences of the elements of Maslach's definition of burnout. Literature has also indicated that the three components of the Maslach Burnout inventory, (MBI) (1993) are manifested in various ways i.e. an individual can experience the emotional exhaustion component but not depersonalization or lack of personal accomplishment. One motivation for conducting the study was that it would be interesting to get a sense of how these three components manifest for the therapist.

Methodology

This section will describe the research design which is a qualitative study, and the method of analysis, Interpretative Phenomenological Analysis (IPA).

Research Design

The current qualitative study examines the experience of therapists in IAPT services. There has been very little research on burnout in IAPT services. The recently published study on burnout (Steel et al., 2015) was mainly quantitative and the themes discussed in this study and the various studies discussed in the literature review suggested that there is a need to explore the relationship between burnout and emotional exhaustion and the impact of burnout on therapists. Due to the nature of this study and the experiences being explored, a qualitative approach is the most appropriate at this point, where very little research has been conducted.

Rationale for chosen Method

The first decision regarding data collection and analysis was the choice of a qualitative design in preference to quantitative. Advocates for IPA (e.g. Smith, 1996) argue that it will provide more useful and meaningful insights into research questions than quantitative methods. IPA has been used largely in areas of counselling and health psychology as much of the research conducted in these areas has been qualitative (Clare, Rowlands, Bruce, Surr & Downs, 2008; Osborn & Smith, 1998). Very little research has been conducted in the area of burnout in IAPT, and much of the research on burnout in mental health is quantitative hence IPA fits well in addressing this gap in research, thus contributing to the originality of this research thesis.

The main rationale for the chosen method is the nature of the research questions however I have considered content analysis, thematic analysis, grounded theory, and discourse analysis. One might argue that content analysis would be a suitable option for interpreting the data however I preferred IPA as I felt it fit with my values within the counselling psychology

profession and ensures that the participant's narrative is at the forefront and is still represented in the final product.

IPA is similar to thematic analysis (TA) as described by Braun and Clarke (2006) and goes beyond TA in offering a more multidimensional analysis. TA can be more descriptive, but IPA offers descriptive, linguistic and conceptual interpretations, hence there may be the opportunity for gaining more value from the data using IPA. According to Pringle, Drummond, McLafferty, Hendry (2011), IPA provides a sense of depth that thematic analysis lacks. One example of IPA offering more in-depth results is Warwick, Joseph, Cordle and Ashworth (2004) who initially used thematic analysis but then used IPA and were able to come up with a richer narrative for their research.

Discourse analysis is about the functions that people use discourse for, what they are trying to do or achieve by structuring or framing the world in a specific way. This was not designed for the nature of my research question. The choice between discourse analysis and IPA was, therefore, a pragmatic one dependent on the goals of research with this research focusing on the experience of participants which is the core of IPA. However, that being said Johnson, Burrows, and Williamson (2004) who conducted a comparison of discourse analysis and IPA would argue that both approaches construct the same phenomenon in a slightly different way but I concluded that IPA was the more suitable of these two for the research question.

Grounded theory was also a contender; however, this approach seeks to give a picture that accounts for a phenomenon and in this research project, the aim is to understand the experience of the participants, therefore IPA was the most appropriate method for this, rather than providing a theoretical framework. According to Willig (2001), many researchers struggle when comparing IPA to grounded theory and, IPA is notably different in its goal of understanding the experience of a phenomenon rather than the social process. While there is

comparability between IPA and grounded theory it is important to note that IPA focuses on the individual which is very relevant to burnout research and the experience of the therapist.

IPA was also chosen due to its relevance to the counselling psychology profession. Counselling psychologists are interested in understanding the experiences of human beings and IPA allows for an exploration of this as such IPA has increased in popularity as a chosen method of analysis. IPA was chosen because its philosophical underpinnings were the best fit for the research. IPA is based on theories of phenomenology, ideography and interpretation and this research question was best addressed using phenomenology rather than grounded theory. IPA could provide idiographic in-depth account of therapists' experiences. IPA advocates the exploration of the subjective reality; the individual describes their experiences and the researcher is able to attach an interpretation of this. This interpretation contains the participant's account, the researcher's own reflections and the theory and research on the concepts the participant discussed. This is also referred to as a double hermeneutic which will be discussed below. Evidently, I have considered a number of alternative qualitative approaches and whilst I acknowledge that other methods would offer valuable insights I am satisfied that my choice of IPA is the most appropriate method of analysis for my study.

The rationale for using an existing concept of the effect of work stress and its three hypothesized components was two-fold. Firstly, to ensure that there was a basic shared understand with participants of the topic being explored. However, interviews and subsequent analysis were conducted ensuring that there was openness to alternative and additional understanding which were recognized and represented in the final analysis (for e.g. using the participants own words or descriptors in the write up and including quotations from the transcripts). Secondly burnout is a well-known and well used concept which would have been likely to be generated organically in the interviews when participants were discussing work related stress.

Hermeneutics

Interpretive approaches to phenomenological research accept that understanding cannot take place without interpretation (Smith et al., 2009). Smith et al. (2009) discussed the hermeneutic circle the concept refers to the idea of the relationship between the whole and its part; in order to understand the whole one must understand the part and vice versa. In IPA reflexivity refers to the researcher engaging in the double hermeneutic by being mindful of how their own experiences and biases may impact on their interpretation of the participants' accounts. Considering my own professional background in IAPT, I attempted to highlight and explore my own beliefs and assumptions and used discussions with my supervisors and colleagues to 'bracket' these (Fischer, 2009), and acknowledge them and the lines of enquiry that emerged from them (Malterud, 2001). In IPA and qualitative research it is understood that the values and identity of the researcher impact on the interpretation of the findings (McLeod, 2001). The process of IPA is interactive rather than linear therefore our understanding of a text takes place at different levels and we move back and forth through different parts of the data. IPA is inherently connected to the twin concepts of hermeneutics and theories of interpretation (Smith et al. 1999). This can be an argument against IPA, as in essence, the research becomes dependent on the participant's ability to articulate themes as well as the researcher's ability to interpret and analyze them (Baillie, Smith, Hewison, & Mason, 2000). In this research this was addressed by conducting a cyclical analysis grounded by the participant's transcript, as well as continuous review of the IPA process using Smith *et a*l. (2013). The supervisory audit of the analysis which is described in the methodology was also used to address this potential problem.

Data were collected using semi-structured interviews to allow participants to openly express ideas and experiences and to gain descriptive data that generated common themes and interpretations in the analysis. The aim was to explore the meaning of therapist's experience

with burnout and their perceptions of how this impacts on the therapeutic relationship with clients.

Phenomenology

'*Phenomenology is a philosophical approach to the study of experiences*' (Smith *et al.*, 2013, p.11). Within psychology phenomenology offers a wealth of ideas as to how one can use research to examine and understand lived experiences. In this research the lived experience being explored from a phenomenological stance is participants' experiences of burnout and similar experiences in IAPT services. Husserl's (1927) 'transcendental phenomenology' aims to identify essential features that help others to make sense of the experience being described by individuals who are sharing their experiences. However, Heidegger's (1962) 'interpretative phenomenology' embraces hermeneutics, understanding interpretation as inevitable due the difficulty one has with detaching from language, culture and their own experiences. Heidegger (1962) describes 'bracketing' as cyclical, requiring ongoing adjustment of pre-conceptions, consistent with reflexive practice, thus when I refer to bracketing it is in reference to Heidegger's (1962) definition. Bracketing can occur in two forms first the researcher identifying and setting aside their assumptions and secondly the hermeneutic revisiting of the data and the researcher's evolving understanding of each aspect of the topic (Fischer, 2009). It is my reflection that bracketing helps facilitate the aim to be led by the participant into novel and unanticipated directions as they share their story (Smith & Osborn, 2008). Within this research I was engaged in the hermeneutic revisiting throughout data analysis and writing this report, fully considering my own personal experiences, assumptions, and cultural factors.

Reflexivity

The issue of reflexivity is integral to all types of qualitative research and it is worth noting that IPA places a considerable focus on reflexivity (Merrick, 1999), and often goes further than other qualitative approaches in addressing reflexivity (Brocki & Wearden, 2006).

There are two types of reflexivity, personal and epistemological (Willing, 2008). Personal reflexivity focuses on the reflection of the researcher as an individual. Consequently, during the research, I reflected on my own values both consciously and unconsciously. I attempted to make the unconscious conscious by using free word association, free writing and drawing (Hollway & Jefferson, 2013). I used the reflective dairy and coding diary with the aim of being transparent. Reflexivity occurs when the researcher engages with the data at all levels while being aware of their biases (Henwood & Pidgeon, 1992) and I trust that I have been able to do this within this research. Epistemological reflexivity explores how the research design has impacted on the knowledge being generated and this has been thoroughly considered within this methodology.

Ethics

Ethical Approvals and permissions

Ethical approval was first gained from the University of the West of England[1] which is included in Appendix A. Prior to applying for NHS Research and Design Approval, my application was reviewed, and amended with my first supervisor. The application was then reviewed by two researchers at UWE. From August 2015 to November 2015, I provided the NRES forms, a CRB check, resume and other personal and professional documents and renewed my Good Clinical Practice certificate to gain AWP Research and Design approval (please refer to Appendix B).

Method

Participants

Demographics

Participants were given a demographic sheet which asks about their age and number of

[1] University of the West of England ethics approval reference number reference: HAS/15/07/188.

years since qualification (a table with this information has been included in the Results chapter). Age has been found to be positively correlated to having more experience of burnout, (Ackerley *et al*. 1988; Ross, Altmaier & Russell, 1989), hence its inclusion in the demographic sheet. Based on previous studies discussed in the literature review participants were asked about the number of hours they worked to be classed into part time and fulltime workers (30 hours or more).

Inclusion Criteria

To be eligible participants met the following criteria:

- Presently working for an IAPT service or having worked for an IAPT service in the last 12 months
- Worked as a therapist in IAPT as a Psychological Wellbeing Practitioner, High intensity worker (Cognitive Behavioral Therapist, Interpersonal Therapy, Eye Movement Desensitization and Reprocessing), Counsellor
- Participants must have held the role for at least one year.

Data Collection

Recruitment and Participants

Recruitment for this study was a three-step process:

1. Two IAPT teams in the South West of England were approached. The researcher met with the managers individually to discuss their team's participation.
2. The manager distributed an email containing a flyer for the research. Interested individuals were asked to contact the researcher by email or telephone.
3. When contacted the researcher discussed the information sheet (see appendix D) with the prospective participant and answered questions about the study. The participant agreed to meet for an interview, consent protocol (see appendix E) was followed

and the interview was scheduled.

Procedure for consent:

- As part of the recruitment strategies described above e-mails were distributed by the service managers asking for people to contact the researcher, and these potential participants were given basic information about the study.
- Interested participants contacted the researcher via email or mobile number provided, an information sheet was sent and an appointment scheduled.

Right to Withdraw

- The right to withdraw from the study was included and discussed as part of the consent form.

Confidentiality

- All participants were given an information sheet which explained confidentiality, the nature of the study and asked to sign a consent to the study if they wish to be involved. Included in the information sheet and reiterated verbally it was stated that confidentiality can be broken should information emerge that gives cause for concern relating to the participant's clinical practice and patient wellbeing (e.g. patient neglect). Participants were advised that the information they provided would be kept confidential by assigning each participant with a pseudonym to ensure that their identity remained confidential. The researcher and supervisors were the only people who had access to the coded data all of which was locked in a filing cabinet or stored on encrypted technological systems.

Participant Distress

- Participants were given the opportunity to ask questions about the research and were invited to contact myself, Crystyn Scott (a counselling psychologist trainee and

Therapist) or my supervisor Professor Richard Cheston, (a clinical psychologist with 25 years' experience of working in the NHS) if they experienced any distressing symptoms from participating. If the participant contacted the researcher or supervisor, they would have been provided with a choice of local helplines or organizations that could support them with the specific difficulty they were experiencing. I felt this protocol would be preferable so the individual would contact myself or my supervisor and be supported by us as part of this process. We were not contacted by any of the participants.

- Each interview was recorded.
- At the end of each interview, the participant was debriefed.

Recruitment ceased when saturation was reached, and no new material was being generated and not no new insights were being gained by the researcher (Glaser & Strauss, 1967; Charmaz, 2006). However, there is contention within academia regarding saturation, as new information continues to emerge the saturation becomes transient (Glaser, 1978). Within this study saturation was first reached with themes such as supervision and emotional exhaustion. At interview nine and ten there was very little variability in the data and no new data were being generated.

Although this was not specified in advance, guidance for IPA (Smith *et al.* 2009) suggested that for an apparently homogenous group of participants as is the case with this research, saturation is likely to be reached after roughly 4-10 participants have been interviewed, hence the sample size is appropriate for both the topic and the method. Sampling in IPA is purposive and broadly homogenous. IPA is focused on convergences and divergences in smaller samples and as such the number of participants used within this study (10) fits with the small sample characteristic that is most suitable for IPA.

Interview Schedule

Following IPA protocol, a semi-structured interview was designed by reflecting on the aims of the study and generating open-ended questions related to those aims. Open-ended questions allowed the participants to settle into the interview and begin discussing their perspectives. Smith and Osborn (2003) explained that this helps the dialogue to flow and allows flexibility to explore interesting and relevant insights that may arise. The interview schedule (presented in Appendix C), allowed the researcher to provide clear phrasing of the questions and ensure the questions were relevant to the research questions. All interviews were conducted face to face.

The interview schedule was piloted with three IAPT therapists who met the criteria for the study, which are outlined below. The pilot allowed the researcher to determine if the questions were appropriate and if the data collected would be relevant to the research questions with the richness and depth that is required for this study and IPA method. It has also been helpful in determining the amount of time the interview would take to ensure it can be completed within the 60-minute estimated maximum length. Pilot interviews were both completed in under 35 minutes. This was an external pilot and has not been integrated to the main analysis, as it was preferred that all participants in the main analysis be people not known to the researcher prior to the interview, to ensure recruitment did not only include individuals who had experiences similar to my own. As a result of the pilot I integrated feedback from the participants who commented that one of my original questions was unclear. I restructured this and applied this insight to a second question, to make that question clearer. When I listened to the recordings of the pilots I noted opportunities for follow up questions and was more mindful of these in the study.

Data Analysis

To follow IPA protocol as outlined by Smith and Osbourne the researcher engaged in the

following stages:

Transcription

1. A first skeleton draft of the transcripts was completed by a confidential transcriptions service. The recordings were edited to remove any identifying details. The researcher then listened to the recordings several times to gain familiarity with the content. The researcher subsequently completed a full transcription of the first recording, including notes made during the interview annotating non-verbal behaviors. Each transcription of the interviews was completed within one week of interview to ensure that the spirit of the interview was retained. I understood that the use of a program like NVIVO version 10 which assists in transcribing and analyzing the data, may have limited my ability to fully immerse myself in the data. Therefore, after consideration during the pilot, I decided to not to use NIVIVO as I wished to follow the IPA protocol described in Smith *et al.* (2009) more closely.

Initial Coding

2. Following recommendations for coding by Smith *et al.* (2009) for each individual case analysis, I created a three-column word document, which contained the line-numbered transcript in column one for each individual transcript (an example of this can be found in Appendix F). The second column contained reflections based on these three key processes. In this second column, the coding utilized three key processes. The first included a descriptive analysis of the words and phrases used by the participants, this was written in blue text. The second was the linguistic exploration of the language, word choice and tone used. Linguistic comments were written in purple. Thirdly, a conceptual analysis (written in red) was undertaken to move away from the explicit to more in depth conceptual explorations.

   The third column of the word document contained the emergent themes. This

involved reflecting on the coding in column two and summarizing this into a clear emergent theme that could be clearly seen to be linked to the participants own words in column one, straight through to column three, and having this be represented visually. I worked with these columns in processed documents on the computer but also engaged with hard copies as this helped me immerse myself more in the data.

Interpretation during the coding involved consideration of the material and paralinguistic markers (Retzinger, 1995), (see table 1 for an example of this). Within this study such interpretations of shame, humor, anger and guilt have been noted. During the process of analysis, I intended to be open to all emotions that were expressed through linguistic markers and these four emotions were the ones that were communicated in this way.

Table 1: Examples of interpretations of paralinguistic markers from Gwen's interview.

Transcript	Paralinguistic Markers	Interpretation
'it also depends on the targets that specific services have. So if the targets are realistic, if I feel it's manageable and under my control' *Gwen 120-123* *'that doesn't seem to be particularly realistic'* *Gwen 135-136* *' well I've basically got to see HI patients every hour and that doesn't seem realistic' Gwen 150-151*	Gwen uses the word 'realistic' several times (repetition) with the first few minutes of the interview. She uses it 6 times overall and the pitch of her voice becomes higher when she says this. I also noticed she became more animated with her hands. Markers of pitch fluctuations and louder speech evident in this quote, were also evident when she discussed the lack of 'support' she experienced. I felt she used repetition to connect these two and reflect her feelings. As Gwen said this her speech was louder and she displayed sweeping hand motions.	One interpretation is that Gwen was passionate about her need for realistic targets and she was angry, and perhaps slightly disillusioned by her circumstances. The interpretation of anger is supported by Lyons' (1977) summation that individuals tend to speak louder when they are excited or angry.

Reflective journal

3. The interpretative facet of IPA is a key feature of the approach, however, and Salmon (2003) notes that "*results of psychological research reflect the researcher as much as the researched*" (p. 26). In qualitative research, the researcher's personal factors and experiences inevitably impact on the research. Consequently, I kept a reflective diary (example included in Appendix G) to show the process of how the themes were selected and how who I am impacted on the interpretation of the data. My thoughts, feelings, experiences and reactions to participants' narratives during the process were documented (e.g. see Smith, 2007). To address the subjectivity, I discussed the code of themes and reflective diary with my supervisory team to ensure there was adherence

to IPA. This was to reflect on how my own assumptions would impact on the themes and to offer a way of monitoring and challenging these assumptions and helping me to be mindful of these issues this helped me to engage in the double hermeneutic. The themes were strongly tied to the participant's own use of language.

Theme identification

4. Each transcript was coded individually to produce a list of themes, consistent with the idiographic approach. Each transcript was checked in relation to the other transcripts, noting contradicting or related themes. A separate sheet was used for each theme and participant and line number identifiers and verbatim quotes recorded on each sheet some extracts of these are noted in Table 2 below. The themes were analyzed with frequent reference to the original text and any conflicting themes were noted and checked against the data for other occurrences before being noted as an isolated theme.

Table 2: extracts from a coding sheet for the theme 'Complexity'

Complexity:
'*about what we do cover, but we might have treated the main presentation, there might not just be a secondary presentation, there could be a tertiary presentation or even more but we don't get to deal with, if we had the chance that client might've been able to get into recovery'* Derrick 153-160
Discharging clients before recover (linked to complexity):
'you're coming into the therapy with two broken limbs which one do we work on first? So it's feeling restricted by the timeframe, understandably I know that we have to have restrictions, there's only so much we can do but it does impact on my feelings of efficacy as a practitioner and from the clients' side of things I guess they have to hear it from me' Derrick, 244-253
Complexity:
'*You are seeing someone once for about 40 minutes, you have to think about risk, it's just go go go and it feels like complexity is just not considered. Anyone can book in, its compounded by that gap in service. I think we see more complexity and its overlooked'* Mary 1502-1508
Complexity
'not having, not being given enough time and support to actually do my work and being, being asked to see patients whose presentations are so complex that I don't feel I'm suitably qualified to actually give them the help they need, which makes me feel deskilled as a therapist, makes me feel guilty, makes me feel that I'm really letting these patients down and yet I know there is no, there is I don't know a way out' Gwen 650-662

Map of the themes and subthemes

5. When each transcript was completed, a map of main themes and isolated themes was drawn up. Themes were grouped into clusters and connections between themes were highlighted. A snapshot of the one part of the process of clustering of themes is provided in appendix H. The researcher reflected on similarities and differences among the themes and the importance that individual participants attributed to the theme. This process involved the iterative (cyclical) and recursive (back and forth) approach understanding the relationships between the themes. A larger map was made for all ten transcripts to analyze the themes.

Superordinate Themes

6. Superordinate themes were generated from the words participants used on some occasions e.g. ‘Supervision’ and others were the result of the grouping of clusters of themes together to form the theme e.g. ‘Therapist Wellbeing’. It was important to remain reflective, reflexive and mindful of the meaning of the individual and highlight the themes that were a true account of the experiences participants shared. Following this literature was reviewed on the main themes to help develop the insight and reflection on the participant’s own narratives in relation to relevant literature.

Validity

As stated, qualitative data are very much influenced by the researcher; no two researchers exploring the same piece of data will produce identical interpretations (Golsworthy & Coyle, 2001). Smith et al. (2013) recommended that Yardley’s (2000; 2008) guidelines should be followed to increase the research quality and validity regardless of theoretical orientation. Yardley (2000) explains good qualitative research will have several sections of verbatim extracts to assist readers in understanding and verifying the interpretations made. These

recommendations and further guidelines by Yardely (2000) were strongly adhered to in this research (see Table 3 for further information on adherence to Yardley's guidelines). I acknowledge that there is a question among researchers whether the criteria for validity to quantitative research is appropriate when assessing qualitative research (Kvale, 1996). To provide transparency and quality, the interpretations have been discussed with the supervisory team to check that the themes are grounded in the data in order that they were able to identify any irregularities (see table 4 below).

Table 3: guidelines from Yardley (2000; 2008) were adhered to within this research.

Yardley (2000; 2008) guidelines	Explanations and examples of adherence
Sensitivity to context-The researcher should demonstrate sensitivity to context including reflection on the socio-cultural context of the study, the interactional nature of data collection and extant literature.	The context of IAPT is described within the literature review. One of the themes generated from the data analysis is 'culture of endurance'. This involved considerable reflection on that aspect of the culture as well as the wider socio-cultural context of the organization, of IAPT and the NHS. Various verbatim extracts from the interviews were included to allow the reader to connect with the voices of the participants and the interpretations being made in this thesis.
Commitment and rigor- The researcher should show in depth engagement with the topic, methodological skill in data collection and thorough data analysis.	As part of the research process, I developed an in depth understanding of IPA and created a carefully thought out and ethical research design. There was continuous reflection on the interview style and the accurate transcription of the interview noting both verbal and non-verbal events. Data analysis was systematic, each theme tied to lists of quotes from all the participants and each participant was quoted at least once in the write up of the Results section.
Transparency and coherence-There should be a clear description of the data and the argument. The study should show a fit between theory and method and reflexivity.	This thesis includes various reflections throughout to highlight transparency of my own stance and how this might have impacted the data. An example of one part of a reflective diary has been included in the Appendices (see appendix G), further reflections were recorded throughout the research. Transparency and coherence are also reflected in the description of the participants, the recruitment process and description of the data analysis.
Impact and importance- According to Yardley (2008) the validity of research is measured in relation to its usefulness and real-world applicability.	Within this study there has been a focus on understanding burnout in IAPT services by exploring it as is, rather than undertaking an intervention. The hope is this exploratory approach will increase awareness of the difficulties these participants' experience. This understanding can lead to further research on interventions and perhaps impact the views of key stakeholders as IAPT continues to evolve.

Table 4: a sample of the 3-column process of data analysis described in text.

Line No	Transcript	Researcher's Descriptive Linguistic Conceptual comments	Themes	Supervisor's comments
406.	your work where you felt burnt	inevitability' adds the ide	Organisational	
407.	out	a conveyed that people are	issue-	
408.	**Respondent:** yeah I'm sure, I,	set up to fail. Suggests there	staffing/turnove	
409.	coming up to Christmas,	are peak difficult times in	r 414-418.	
410.	Christmas is always a busy time of	the service. 'Lost' suggest	Staff sickenss-	
411.	year for mental health services	accidental, which contrasts	425	Supervisor 1:
412.	anyway but this one was	his narrative above. Lost		Sounds accidental!!
413.	especially busy and we'd lost	also suggest that they were		Interesting choice of
414.	quite a few members of staff at	perhaps worthy of staying		words
415.	once and so I found myself	or missed. Attributes people		
416.	covering phenomenal amounts of	leaving to their character		
417.	surgeries or clinics, doing lots of	and needs and the lack of	Fear of being	
418.	clinics, that alongside that at the	support in the service.	judged /Shame	Supervisor 1:
419.	same time I had lots of, we'd	'Phenomenal' is indicative	426-428	Interesting - seeing
420.	applied for some research funding	of the overwhelming nature		the tension in the
421.	and that had come through for	of his experience. He has his		service, the paradox.
422.	autism stuff and because I'm the	own role, to do but the		Repetition of ironic
423.	only guy that does that, that was	organizational issue of		
424.	all in my room to do and I just	staffing problems was		Supervisor 1:
425.	couldn't cope, I just felt	added to that putting more		You …. You …. I think
426.	absolutely, so I did go off sick for a	pressure on him. Difficulty		about it. Important
427.	period and I never told them, I	coping. Lack of time.		change of reference
428.	said I was off sick with a cold but I	Demand outweighing	Organizational	Supervisor 2:
429.	just needed a break and I didn't	personal resources. This is	culture of	I agree that this
430.	want to site stress(pause) which is	an addional issue being	endurance-430-	section is central –
431.	ironic you know, it's ironic in	raised in the narrative, he is	433.	identifying the
432.	somebody who works in the	lacking space to do the		problem and the
433.	mental health services saying	work. He attributes sickness		impossibility of
434.	"you're not in stress" yeah or the	to physical issue indicating		naming it lest he is
435.	fear of that because you don't	concerns about being		seen as not coping.
436.	want people to think that you	judged for not coping. It is		I'm interested in
437.	can't cope which was hilarious	indeed 'ironic' that in a		how this culture
438.	when I think about it now, it	therapeutic environment		impacts on attitudes
439.	seems pretty crazy but umm but	stress might not be a		to clients who arrive
440.	yeah. So that was interesting,	reasonable response. Feels		because they aren't
441.	that was an interesting	it's not right to have a		coping well. How do
442.	experience that at that point	negative environment at		you view this?
443.	umm	work. Describes his service		Supervisor 1:
444.	**Interviewer:** if you don't mind	as one where it is important		Belittling language -
445.	me asking why did you feel it	to get on with it. He can		or diminishing the
446.	wasn't ok for you at that point to	gone back to distancing		significance
447.	sight stress	language when he is talking		
448.	**Respondent:** because of the	about something		Supervisor 1:
449.	culture, because of that culture of	challenging. There Is a	Unhealthy/Dang	Dichotomies,
450.	you get on with it. You know you	problem and he is unable to	erous	distancing
451.	put up and shut up, sink or swim	name it, for fear of being	environment	
452.	you know that that culture of you	seen as not coping. My	451-452	
453.	know thrive or don't you know	impression is that this is		

Table 4 provides an example of the data analysis and discussions with the supervisory team. These written notes form part of the discussions and reflections. Additionally, a sample of the analysis has been included in appendix F.

Reflections on the Research

Throughout this project I was mindful of my own subjective experiences and reasons for wanting to do this research. I have worked in two IAPT services during the course of this project. At the time I began the proposal I worked in a team of committed and dedicated colleagues who often disclosed mental and physical health or work-related difficulties. There was a high rate of sickness, particularly long-term and a high level of turnover, documented and observed. At the time I identified as having some stress but did not think I was experiencing burnout. I wanted to learn more about it and the specific characteristics of IAPT that influenced the experiences I witnessed.

I was aware my own thoughts needed to be well documented to engage in good IPA analysis. Often, I felt I did not have a strong opinion of the phenomena participants described and was more curious about the experiences or viewpoints of others. During the period of analysis and data collection, I found myself in another IAPT team quite different from my previous team. I became even more curious as to the experiences of my participants as even in two teams my time in IAPT was vastly different. I kept a reflective journal which helped me track and understand the research process.

I believed all my participants in the pilot and actual research were ethical professionals with ethical practices. I was careful not to share my own experience or thoughts to collude or disagree with them.

I felt the research analysis was led by the participant interviews. I focused on the material, then reflected on how they related to the research questions and scope of research. I felt privileged to witness their narratives and perspectives and experienced a passion and gratitude which meant I owed them an accurate representation of their experiences. In the discussion below, I focused on the relationship between the findings and current literature, presenting insights that were both supportive and critical of the findings. As discussed in the

methodology I used the reflective diary and supervision to help ensure my interpretations were grounded in the data. I will now present the findings.

Results

Overview of Findings

The analysis revealed three superordinate themes: Therapist Wellbeing: Caseload Challenges; and Organisational support. Therapist wellbeing refers to the impact of the participant's roles in IAPT on their emotional, mental and physical health. Within this theme participants' sense of personal accomplishment, and ability to cope with their roles both contributed to burnout. Participants faced challenges within their caseloads such as the number of clients and the complexity of the material clients brought to the session. These both impacted on them as therapists and on their view of the manageability of the role. The experiences they shared around this topic have been grouped under the theme Caseload Challenges. Thirdly, Organizational Support refers to the ways in which the organization cares for staff. This includes supervision, time for reflection, training and the culture within the organization.

In line with Smith's (2011) guidelines for quality IPA, each superordinate theme is present in all participants' transcripts (see Appendix A for a table showing the frequency of themes). The hierarchy of the themes is presented on two levels. First, the superordinate themes are discussed, then each sub-theme is presented. Themes are discussed in terms of frequency and the meaning it holds for individuals and the sample. Extracts and short quotes have been presented from individual transcripts. Extracts have been numbered and identified by the line numbers in the individual transcripts. Within the extracts included in this chapter, attention will be called to key terms and phrases which highlight key points of analysis. Salient features of participants' accounts have been presented to direct the reader's attention to commonalities and divergences within the narratives, and areas that were important for individual participants.

The participants

Table 5 describes the demographic details of all participants. All participants were white persons from Britain or European countries who currently work in IAPT services in the South of England. They included one assistant psychologist, two psychological wellbeing practitioners, three high-intensity trainees and one high-intensity therapist and two counselors. Some of these therapists identified as psychology practitioners and their preferred title is noted in the table below. Many of the therapists offered different types of therapy such as counselling and CBT, a mix of step 2 and step 3 work (as described in definition of terms section) and group work or supervision.

Table 5: key demographics of participants.

Participant	Age	Current Role	Average time in IAPT (years)	Number of years working as a therapist
Brad	38	High-Intensity (T)	4	4
Stacy	37	Psychology Practitioner/High Intensity (T)	8	10
Gwen	55	High Intensity (T)	7	14
Mary	31	Psychology Practitioner	5	11
Tania	35	Psychology Practitioner/Counsellor	5	10
Chris	57	Counsellor	6	10
Susie	31	PWP	3	3
Derrick	53	High-Intensity	3	6
Tessa	24	Assistant Psychology Practitioner	2	2
Brianna	26	PWP	4	4

Key

(T)-Trainee, PWP-Psychological Wellbeing Practitioner

[pause] indicates a pause in the conversation.

() indicates lines of the extract that do not relate directly to the theme being discussed.

This key had been adapted from Morgan (2011).

Quotations are used from each of the participants. Some transcripts were richer i.e, more descriptive that others and may have been cited more for that reason. Quotations offer a deeper understanding of the narrative.

Within the results and discussion, I have used the extract number and a letter to refer to specific areas of a quote I discuss in text. I have used [] to highlight specific parts of the quotes I discuss in the results, and underlined phrases that emphasised the parts of the quotes that were most relevant to the theme being discussed.

Three super-ordinate themes with multiple sub-themes emerged from the data following Interpretative Phenomenological Analysis as summarized in the table below.

Table 6: Organisation of Themes across the sample

Super-ordinate Theme 1: Therapist Wellbeing	**Subtheme 1a**. Therapists' emotional, physical and mental health and resilience
	Subtheme 1b. Participants' ability to stay in their roles: Sustainability
	Subtheme 1c. Participants' experience of personal accomplishment.
Super-ordinate Theme 2: Caseload Challenges	**Subtheme 2a.** Participants' experience of high caseloads and complex client presentations.
	Subtheme 2b. Participants' experience of the therapeutic relationship
Super-ordinate Theme 3: Organisational Support	**Subtheme 3a.** Participants' experience of supervision and time for reflection.
	Subtheme 3b. Participants' experience of training
	Subtheme 3c. A culture of endurance.

Super-ordinate Theme One-Therapist Wellbeing

The participants provided a wealth of insights into their experiences in IAPT services in relation to burnout and wellbeing. All participants disclosed the difficulties they experienced with working in challenging environments. They described experiencing negative impacts, which participants framed as burnout or different levels of burnout, high stress, and mental health challenges. All the participants described witnessing this within their teams, and at some point, experiencing it themselves. Some participants were reflective about their efforts to prevent the unfavorable effects of stress and burnout for themselves and their clients. Therapist wellbeing will be broken down into three sub-themes.

Subtheme 1a. Therapists' emotional, mental and physical health and resilience

The first subtheme relates to participants' understanding of their experiences and the various ways they were impacted because of their roles in IAPT. The most common phenomenon was an emotional impact. Therapists within this study described themselves as '*exhausted*' (Gwen, 423), '*depleted*' (Stacy, 64) and overwhelmed- '*I wish I could just leave*', (Stacy, 556-567). The difference between the resources used as a therapist and in other occupations was often drawn on to illustrate the importance of one's emotional resources.

> *[1]. I can really identify that there are certain [1a] distinctions between burnout for a banker and burnout for a psychological therapist. [1b] It tends to be more of an emotional component, psychological therapists. (Brad,* 90-99)

In his interview, Brad shared his awareness that various professions are impacted by burnout but here he highlighted the '*distinctions*' Brad [1a]. This distinction is the emotional resources, essential for the role of the therapist, my interpretation is that it is like a plumber coming to a job without his toolbox. The '*emotional component'* [1b] described here reflects how Brad experiences the role of a therapist as having a high degree of responsibility, he describes '*holding*' and '*containing*' (Brad 66-67) difficult experiences daily. Brad's experience here reflects the experiences shared by the ten individuals in the sample.

Strongly related to emotional wellbeing, mental health was raised by more than half (six) of the participants. It was conveyed by Tessa, Susie, and Mary that their own mental health experiences were a reason for entering the profession. Conversely, it was an area that could be affected by work-related difficulties, i.e. work could be a trigger for episodes of poor mental health. Mental health was also used by Tessa, Brianna and Stacy to refer to the need to keep themselves mentally well. Two participants will be highlighted here due to the significance of their experiences and polarization from the shared experiences within the sample. Chris described going to a general practitioner and discussing his Post-Traumatic Stress disorder (PTSD). He felt this was a response to training that he had recently received. He reported experiencing visual and auditory hallucinations and flashbacks of his friend who had killed himself thirty-two years prior. These symptoms began immediately after the suicide prevention training.

> *[2]. () and he (his doctor) said 'what do you think it might be? It sounds like PTSD to me.' Now, I'd lost my framework, I knew where I was and I knew what was going on but I really was worried that I would not be coming back to work and I really was quite confused (*Interviewer*: yeah, yeah) and I was having these nightmares and all the rest of it and so I said yeah and I went away going cor blimey, but he was actually asking me. I think if we said it was a traumatic event that had tested my mettle that would be different and the occupational health doctor when I got to see him, excellent guy by the way, and he said depleted psychological batteries and I think that is more like burnout than anything else* (Chris, 1202-1222).

He was very expressive in this quote, he began by discussing the PTSD, then tied this experience closely to burnout. As he mentioned the doctors, he used these professional opinions to validate his expression of his thoughts and experience.

Brianna's experience of mental health offers a slight contrast to Chris, in its focus on keeping well. Brianna who had a mainly positive view of her experiences of working in her current IAPT service, described continuously working on her own anxiety and perfectionist traits which were often triggered by her role. Initially, she was very affected but, over time, she engaged in therapy and reflections which helped her to manage her experiences.

[3]. I think it (impact on mental health) did feel very much kind of related to the, to the job. Umm but I think you know I mean I'm, I think I have a tendency to worry anyway but I think yeah just, just working in this kind of job and also kind of struggling a bit with perfectionism as well, feeling that you know one thing to do kind of a really good job obviously you know I think I've accepted now it's about doing a good enough job isn't it (Brianna, 629-640).

A further two participants (Gwen and Tania) described experiences that were interpreted as being related to low mood which was expressed by them as part of their experience of burnout.

[4]. Everything upset me a lot, I became increasingly tired, couldn't sleep properly anymore. I would wake up in the early hours of the morning, not being able to go back to sleep and the first thing I noticed in the mornings was that I had a lot of noise in my ears and I couldn't switch the noise off anymore, it was just constantly there, so there was just sensory overload constant noise, not being able to speak, feeling more and more tired. That affected my thinking, my productivity, my mood. (Gwen, 290-302).

Above, Gwen discussed her affected sleeping and its impact on her functioning and mood. The ability to keep oneself in good mental health was affected more widely within the sample as participants found it difficult to balance personal life and work challenges.

Thirdly, physical health appeared to be the most easily discussed area impacted by burnout. There was a sense that those struggles were easier to verbalize. All participants discussed feeling tired, irritable and having difficulties with sleep as some of the clear markers of burnout. One example was Derrick who had been off sick recently with burnout (his own explanation) he explained that a drop in physical capabilities, wellness and immunity would be his usual experience of burnout, and was on this occasion. During the study, it seemed to appear that men were more likely to notice their physical symptoms than their emotional symptoms within their idiosyncratic experience of burnout. Similarly, Chris, first raised his chest infection as one of the reasons he was off sick but as the interview continued he spoke more freely and highlighted burnout as the main issue.

> *[5]. The last month I've been signed off sick and it isn't just because of therapeutic burnout, it's because I had a medical infection here (taps his chest), I attended a training course as part of my work here (*Interviewer, *simultaneously: ok) and the training course was quite traumatic actually* (Chris, 91-99)

Overall physical health issues were present in the experience of burnout, participants either described the physical health deterioration as a direct result of their work experiences, or it being an organic illness which also affected their wellbeing when they were experiencing burnout. In my own interpretation, it appeared these physical health experiences, for example Chris's medical infection were more easily discussed than the emotional and mental aspects of burnout. Perhaps there was a belief that physical illness was a more socially acceptable illness or difficulty.

The experiences shared by the participants in this study were not only focused on poor wellbeing, but also on resilience, which refers to the ability to bounce back from, or actively avoid these emotional, physical and mental health negative impacts. Resilience was not discussed frequently but when it was discussed participants reflected on it as being important. Some participants (eg. Brianna, Tessa) used the word resilience, others referred to coping strategies and these have been grouped under *resilience* as part of the process of grouping the themes. Resilience was mainly discussed by two participants: Brianna, who experienced less stress and burnout since changing IAPT teams and re-accessing social support; and Tessa, who focused much of her reflections in the interview on her efforts to keep well. They described feeling emotionally drained and stressed but felt there were strategies that helped them to cope. Susie briefly shared her views on resilience and what this meant to her.

> *[6]. Interviewer: so you've mentioned taking it to supervision what else do you do to kind of stop yourself being burnt-out?*
>
> *Susie: umm so something I've learnt since doing this job is about looking after myself, I think because that was something I found really difficult to do, like if I was ill to actually have a day off umm I've got quite a, a work ethic of you just carry on but umm you know actually I think being able to look after yourself and thinking actually I'm not fit to work is, that's been a learning*

> *curve for me. Umm but I've had personal therapy through the training that I've done as part of that and umm I've just started going back to that now, that's been really important for me building my resilience I think which helps prevent burnout I think, having that space where you can think about really what's going on for you umm building on knowledge and awareness of yourself I think umm again you, kind of I feel like I've learnt more about what might you know bring something up for me, what that's about, what my own reactions are and being able to separate that from the client, being more aware of what's going on for me in the room I think. Umm and then doing, I guess some of the things you, kind of preach about as it were in sessions like you know taking time out for yourself, thinking about your needs, being able to communicate those needs to other people umm you know and taking relaxation exercise outside of work and having that time for myself, getting, having a good support network around me both at work and at home have been things that I really find useful in sustaining doing a job like this (Susie, 183-227)*

What Brianna and Susie seem to be referring to could be understood as an aspect of resilience that relates to coping strategies and particularly those which are aimed at making up for what individuals perceive as their own vulnerabilities (Skovholt & Trotter-Mathison, 2011). For example, some took time on the bus between locations to reflect on clients, others practiced mindfulness or engaged in personal therapy. This was a continuous task for individuals and it was apparent that the time they put into it outside of work might not be there for others. However perhaps developing resilience can be a buffer to burnout. Brianna offers two examples below that contributed to her need for developing coping strategies.

> *[7]. I think umm so I think it just, it just felt, I just felt like I was not giving the people the best kind of treatment that they deserved really. Umm I suppose you know the reason why we go into this job is because we, you know want to obviously support people and you know empower people so that they'll perhaps be able to improve their wellbeing and it felt like actually you know I wasn't able to do that umm and it just felt like it was really not that great a service giving people. Umm I think sometimes it's, [7a] it feels deskilling really umm because you know we're trained to work with this group of people that actually I don't think many people are just that straight forward, I think they are quite complex in general umm (Brianna, 460-479).*
>
> *[8]. Yeah I think it (burnout) was, I think it did feel very much kind of related to the, to the job. Umm but I think you know I mean I'm, I think I have a tendency to worry anyway but I think yeah just, just working in this kind of job and [8a] also kind of struggling a bit with perfectionism as well, feeling that you know one thing to do kind of a really good job obviously you know [8b] I think I've accepted now it's about doing a good enough job isn't it!? (*Interviewer*: yeah,*

> *yeah) umm so yeah I think that was quite, quite a big sort of lesson really umm yeah* (Brianna, 629-644).

In these extracts Brianna offers a picture of the factors that impact on her resilience, she describes client complexity, her training and her own tendency to worry as being influential. In [7a] she suggests that there is a mismatch between her training and the groups of people she sees. My interpretation is that this is connected to her statement in [8a] where she describes her own self-identified vulnerability of struggling with perfectionism. Together this mismatch and her own vulnerability affects her resilience. To help her cope she is attempting to be compassionate to herself in saying '*I think I've accepted now it's about doing a good enough job isn't it?*' [8b]. The linguistics of her statement '*I think*' and the tone of her voice when she says '*isn't it*?' suggests she is still trying to accept her own statement and is also seeking reassurance that it is okay to be good enough. These two extracts reflect the internal and external factors that impact on resilience for Brianna.

<u>Subtheme 1b. Sustainability</u>

The ability of individuals to stay employed within IAPT was discussed by participants in relation to them taking time off sick, being in full-time versus part-time employment and the turnover rates of staff. All the participants described either having time off sick themselves or reported their colleagues having time off due to what they understood to be work-related stress or burnout.

> *[9]*. Interviewer*: you said there were people off for the whole, a lot time you were there?*
>
> Brianna*: yeah, yeah, yeah. People that went off sick umm one of my umm someone I worked with, [9a] my lecturers in the service was went off sick as well umm and then some of the high-intensity therapists were off sick. [9b] One of my good friends in the service went off sick for about 3 months (pause) umm* (366-377).

This quote is interesting as throughout the interview Brianna speaks slowly, carefully almost hesitantly but here she seems to increase the speed of her speech initially and becomes more animated. Throughout the interview Brianna mainly discussed her efforts to keep well,

however, occasionally there were small comments that provided insight into Brianna's motivations towards working so hard to keep well. Extract nine provides an example of this is she describes [9a] '*lecturers in the service*' going off sick and she highlights that high-intensity therapists are also off sick. From this one might interpret that perhaps she sees these as people who are superior, i.e. these individuals hold more important positions in the service and she reflects on her observation that even they are struggling to cope. Linguistic markers of this are present in the slowing of her speech and high inflection as she says this sentence. For example in the extract above Brianna uses the word '*umm*' several times, she slows her speech each time she commented on who was off sick, as she says the words '*one of my good friends in the service went off sick for about 3 months umm*' her speech becomes even slower and there is a brief pause, as she appeared to be thinking about or reflecting on that memory. She goes on to state that she understood this was from burnout but reflects on other personal factors that might have contributed to this. The extract below reflects these sentiments in her own words.

> *[10]. (Continues from the extract above [9])* Interviewer*: was that related to burnout, related to stress?*
>
> Brianna*: yes definitely. I think, it think it was I mean obviously we all bring our own experiences don't we into this work but I think umm yeah I think yeah it very much was related umm just the amount of pressure [10a] it felt there was from above to kind of meet targets and felt like everyone was talking about targets a lot of the time and yeah. (379-389)*

It can be interpreted that her understanding of many people being off, is that it was a systemic organizational issue. The first line of the quote refers to a statement she made earlier - *' It's such a different atmosphere and I think I really liked the team that I worked with but I think it was just so obvious that there was so much pressure coming from above umm so many people on long-term sick leave that I never kind of met you know over sort of, you know time that I worked there' (Brianna,338-346)* stating that several staff members were off sick for the duration of her employment of around one year, with a previous service. One way of

interpreting this that it is a systemic issue is related to the *'pressure'* [10a] coming from above that she described, and her report that many people were off.

Five of the participants commented on the difference between those who worked part-time and those who worked fulltime. There was a consensus amongst all participants that fulltime work limited the sustainability of the employment. They were more likely to leave employment or go off sick. Part-time therapists who experienced burnout, suggested that they were concerned about their full-time colleagues.

> *[11].* Tania*:() 'I work part-time, umm I couldn't manage any other way. [11a] This is not the kind of job you can do fulltime. It would just not go on long-term. In many ways it would make us even more [11b]* expendable*.'* (305-310).

Tania provides one example here of her reasoning for working part-time. She felt there was already not enough time for her to complete her work and that her time constraints would just be exacerbated in a full-time role [11a]. The use of the word '*expendable*' [11b] was interpreted as a combination of her views of how the service was managed and how she felt management saw employees within IAPT as a whole. Several participants (e.g. Stacy) expressed that IAPT workers are not long-term employees due to the pressure in Extract 12 below.

> *[12]. 'I remember my, one of my CBT supervisors back in the day saying to me really you should, you know you should only really do 10 years in this job, in this line of work and I think well I've done 8 years, which is quite a lot and I've still not even you know as sort of qualified' (Stacy, 684-690).*

Participants reported that they had experienced high turnover in the teams in which they worked. Several participants had changed roles in the few years that they were employed in IAPT. The most common form of change were attempts at progress and role diversification. My interpretation is that participants felt that this was one way to improve their situation without leaving their jobs completely. Participants (Brad, Mary, Stacy, Brianna) attempted to specialize, for example as the lead in a department, offering supervision or completing training that would allow them to explore their other interest or

move away from direct contact with clients, as this may have been more of a drain on their emotional resources.

In this study, Brad and Tania were keen to leave the team they both worked in together, due to lack of organizational support and related difficulties. Susie obtained a role as a Clinical Psychologist (trainee) and felt her time in IAPT had come to an end. Other participants, Gwen and Brianna had changed IAPT services or diversified their roles during this time and continued to look for opportunities for change, which they felt would be beneficial regarding sustainably. '*Sustainability*' or '*sustaining*' as a term, was used by a few participants (Derrick, Tania, Tessa and Susie) as the word used to describe changes to one's role (due to pressures inherent in the role) which could make their work more manageable, therefore, it felt important to use their word to report this theme.

Sub-theme 1c. Personal accomplishment

The theme of personal accomplishment (PA) was discussed by all participants, and elements of the theme were interwoven throughout nine of the interviews indicating the importance of this. Some participants linked personal accomplishment to their identity and their reasons for originally wanting to become a therapist. Feedback from clients was important to the participants, however, recovery rates (percentages of clients who had recovered) were less utilized by the participants themselves.

Tessa was one participant for whom the importance of personal accomplishment was strongly linked to burnout.

[13]. Tessa: *yes but it's the assessments that have been the most difficult I think.*

Interviewer: *ok, do you want to tell me a bit more about that?*

Tessa: *so I think with the, if you're doing assessments day in day out then I think personally I find that's when I'm <u>most at risk of burnout or feeling stressed because you don't get a sense of achievement</u> or don't get a sense of follow up with that client at all. It's very much you see that person at their most distressed, which is obviously takes an emotional toll on you as a person*

> *and you don't get that sense of helping them through that difficulty in any way so you're almost just left holding that emotion and working out what you do with it, what's theirs, what's yours and what, as I said personally I think that's the most difficult bit for me.*
>
> Interviewer: *how do you manage that like being left with you know seeing that person at their most distressed and then kind of moving onto the next person?*
>
> Tessa: *umm if I have time between assessments, so usually if that person's very distressed I will, [13a] I'll give a bit more of myself. So I give them a bit more time but that can lead to assessments being very close together so you maybe only get a couple of minutes to go to the toilet or grab a drink and then you're onto the next one. In terms of how I manage that I tend to take a few deep breaths at my seat and kind of ground myself there and then try and put it out of my mind or at least compartmentalize it in some way [13b] but I'll end up very stressed at the end of that day. (1155-1206)*

Tessa is aware of her triggers and seemed to build this awareness during the interview. It appeared that the interview evolved into a reflective space for her. Three other participants (Chris, Mary, and Brad) commented on the benefits of this reflective space. In this extract from Tessa, we see the clear link with her engaging with a continuous flow of difficult material and not having the opportunity to help these clients. She is left holding their emotions and hers. She then states, [13a] '*I give a bit more of myself*', her speech slows, and this appears as a small insight into the conflict for her; she is already stressed and having less time with the client might give her space but giving them more time might provide a greater sense of accomplishment. She cannot have both and struggles. The last line of the quote shows that neither option leaves her less stressed. Later in the interview I share a definition of burnout and Tessa laughs, it resonates with her and her experience of the difference between stress and burnout. She felt PA for her and her colleagues mediates what they refer to as high stress.

> *[14].*Tessa*: umm I'm going to say for the benefit of the tape that I'm smiling.(laughs) Yeah, yeah that sounds like umm sounds like high stress to me yeah that, that fits so the sense of and I think that's when we were talking about sense of achievement not being stable I think it's when my stress levels go up and down*
>
> Interviewer*: yeah*
>
> Tessa*: so it's that.* (890-900).
>
> Brianna shared similar experiences:

> *[15].yeah and I think sometimes it's difficult to sort of separate that umm because it feels I don't know because then it's, it's hard because you think you know [15a]am I just rubbish at my job or is it that you know actually I've just not got the training to work with these people or, or you know and, and yeah so that, that feels quite anxiety-provoking, kind of doubting yourself that you know* (Brianna, 511-521).

> *[16]. Umm but yeah I think no (inaudible) as people know this is the minimum standard you know. You, you just have to kind of do this it just felt like there was just no wiggle room and I think as a result you know it was really affecting the staff's kind of wellbeing and it's also I something about you know because I think our managers were so stressed themselves and there wasn't that, it felt like everyone was just being so kind of rigid with that and perhaps we weren't communicating in a you know perhaps very therapeutic or understanding way with each other you know umm yeah so* (Brianna, 671-686).

Similar to Tessa, Brianna explained her sense of personal accomplishment was strongly tied to whether or not she felt she was helping her clients. There appeared to be a continuous internal conflict for her as she struggled with self-blame or acknowledged the external limitations of her role- [15a] '*am I just rubbish at my job or is it that you know actually I've just not got the training to work with these people or, or you know*.' Her sense of personal accomplishment can be low at times if she myopically focuses her inability to go beyond maintaining the minimum standard but this (sense of personal accomplishment) is lifted if she reflects on all the limitations of the training and the environment. Insight into the environment was evident in the statement [16a] '*we weren't communicating in a you know perhaps very therapeutic or understanding way with each other you know umm yeah so*' which suggested that as a team the staff were very stressed and there was not a lot of time for validation and support, which felt important to Brianna.

Superordinate Theme Two-Caseload difficulties

The Theme of caseload difficulties refers to client related challenges that impacted on participants' roles. These include the number of clients that practitioners were expected to see in a week and the complexity of the presentations of those clients. These factors then impacted on the therapeutic relationship.

Subtheme 2a. High caseloads and complex presentations

IAPT is a high-volume, short-term therapy service, however the clients who are seen within IAPT have much more severe problems than are appropriate for short-term therapy. All participants commented on complexity, with the view that clients who presented to IAPT services were largely not the clients that they expected in that they were more severe than the targeted group of service users. For example, PWPs were expected to see clients with '*mild to moderate*' (DOH, 2008, p.6) presentations. Most participants saw clients for low-intensity interventions or guided self-help as part of their role. They reported that these clients were more complex than mild to moderate and that in reality people who fit this diagnostic label were a rarity. Interestingly, participants were not against working with complexity as a rule. Some found it enjoyable and a positive challenge. Others felt that people were complex and there was no way around that; the difficulty they experienced was about the time they needed to prepare, the limited time for supervision and their other needs that were not considered when working with complexity. Derrick suggested that if more space could be given when the therapist was working with complexity then more could be done with those clients while still meeting the needs of the other clients on the caseload. Similar comments were made by Susie (153-160) and Brianna (450-479).

The number of clients that the therapist was expected to see was frequently discussed with contention within the sample. Several therapists discussed seeing clients 'back to back' with no space for preparation, admin or reflection considered.

[17]. Interviewer*: how many clients would you say you see a week?*

Gwen*: umm altogether about 20*

Interviewer*: 20 a week*

Gwen: *yeah*

Interviewer*: and that's in 3 days?*

Gwen: *in 3 days yeah. (10-15).*

Gwen has shown an attitude of commitment and perseverance within a team that appears to have a culture of endurance in the face of adversity. However, Gwen is seeing twenty clients mostly for forty-five minutes to one hour each week, and the administrative tasks and time that is needed for such a workload apprear to be insufficiently considered by management.

Generally, within the sample high caseloads impacted on the therapists significantly, resulting in stress and strain, and the time that they had with clients was pressured. Stacy and Brad shared that there are times when they hoped their clients would not to attend. This was not because they disliked the clients but rather it allowed them time for other tasks and reflection. Therapists relied on the DNAs (when clients Did Not Attend) as a reprieve in a stressful role. Brianna explained that in a previous IAPT team in which she worked they were expected to make other client contacts if they had a DNA, so even this time was being accounted for, diminishing therapists' flexibility.

> *[18]. while I started to feel quite… I don't want to use the word resentful of my patients that's unfair but I started, that therapeutic sense of just not sure what to bring or how to bring it. I almost felt as if umm the therapy sessions were becoming less effective and I was aware of that and in that sense umm yeah I started to become almost …[18a] anxious about seeing people …and you are hoping for the next client not to come…and you feel bad but at least I can go to the toilet or something. Then I feel [18b] guilty… because I know they need help.* (Brad, 484-495).

There are paralinguistic markers of shame included in this quote such as soft tone, rapid speech, and laughter (Retzinger, 1991, 1995). Within this quote, his speech slows and he has a slight pause before he says the words '*anxious*' (18a) and '*guilty*' (18b). One argument can be made that these markers can be interpreted as Brad's feelings of guilt and shame towards hoping his clients' DNA. This might arise from the possible incongruence he experienced, firstly his understanding that the client needs therapy, however also contending with his own feeling of being overwhelmed and needing space and time to reflect.

Complexity can be highlighted from another angle; there are service users who are not suited to IAPT however a provision of care has not been made available to them i.e. a service suited to them has not been created within the national health care services. In some regions in the United Kingdom and Scotland, there are specialized services between secondary care and IAPT, however in several regions, including where this research was conducted, many clients require alternative services which are inaccessible. These services may include personality disorder specialist teams, or interventions like dialectical behavioural therapy, compassion focused therapy where NICE recommendations suggest these are preferred to CBT for various presentations. One example of a practitioner who has noticed this gap is Derrick. Derrick is a very reflective practitioner and is keen to provide the best for his clients. However, when some difficulties cannot be accommodated in the space the service provides he comes back to a sense of failure, which he internalizes. Extract 19 highlights his awareness that there needs to be a shift in the way complexity is managed.

[19]. Interviewer: *ok do tell me a bit more about what you mean by screening and complexity?*

Derrick: *well previously I think when there were allocations to individual therapists, within the service there would have been a process of screening before allocating out to, in many respects assess whether individual clients umm were suitable for the specific levels of therapy that they were being brought forward for and put forward for and for the service to know about the degree of complexity and that's just unfortunately not the case. You find now that it transpires when you're working with the clients because the screening is no longer in place, you could be 6 sessions in and start to think oh there's a personality disorder presenting here which might've been picked previously. (60-85)*

Derrick's tone of voice and facial expression reflect the conflict he experienced in not being able to fully address the needs of those clients. Another example of this is highlighted by Tania below, who directly speaks about the gap between IAPT and secondary care.

[20]. *'umm it does really vary and again I think that's because, because, because anyone you know it's open door anyone can book in, I think we're seeing more and more complexity of people from you know secondary services or umm people that aren't severe enough to be taken on by secondary but will not typically fit an IAPT service that kind of gap in the middle. I think we see a lot of more*

> *complexity than maybe other IAPT services that will only kind of, kind of see anxiety, depression more of the typical IAPT service'* (Tania, 442-435).

Tania describes the gap and the implications for staff working in IAPT services. This means that in her experience there is more complexity within the services and in my own interpretation of that, it might mean that services might operate to meet demands they were not designed to meet.

Subtheme 2b. Participants' experience of the therapeutic relationship

Drawing on the themes throughout, the impact on the clients and the therapeutic relationship was discussed. Notably, at the forefront of all participants' minds was the service they were giving to the clients, often at their own expense. Six of the participants referred explicitly to the reasons they became a therapist and how this impacted on them within their current roles. Therefore, the commitment to the clients was present, however unintentional implications of therapist burnout and stress were also there.

The therapeutic relationship was discussed by all participants. From their reports these alliances were generally well maintained. As the participants became more stressed or burnt out they may have impacted on these relationships without their direct awareness. Therapists felt guilty about staying home when they were unwell and would often try to persevere resulting in further stress and strain. For two participants, Chris and Derrick, they discussed '*professionalism being jeopardized*' (Chris, 124-125) and '*not (being) fit to practice*' (Derrick, 624-525) as the way they processed experiences and gave themselves permission to be off sick from work. Participants prioritized the implications for their clients over their own value of their wellbeing. There was a sense that their own wellbeing was an insufficient reason to stay off work when sick. There was evidence that some relationships were so well formed that clients chose to wait to see that therapist while they were off sick for more than a month. One example of this is provided by Chris below:

> *[21]. 'and I find the person who's covered for me, like I mean I try very hard to play the game and I think they've done a very good job. Some old girl she went to see, she was in one of my surgeries and the first patient said well I, you're very nice but I don't really want to talk to you, I only want to see Chris and then the second patient came in and said exactly the same.* (Chris, 1290-1300).

The following extract from Brianna reflects the interaction between high caseloads and the therapeutic relationship.

> *[22]. Some weeks I've worked on Saturday, I did 5 assessments and I did umm <u>just kind of think that I really hope this person just doesn't turn up,</u> which is awful, it's really bad because actually you know that person clearly is referring to the service because they want support but yeah I think there is that you know, oh I've got so many people on my caseload which is, it is I suppose you know depersonalising the people that we work with isn't it kind of think it as oh I've got this number of people on my caseload rather than you know I'm working with this person who's experiencing this you know umm so yeah I think, I think you know* (Brianna 706-721).

Brianna appears to be struggling with the number of people she sees in one day, at times her caseload has meant seeing more than 5 people. This then impacts on her ability to be emotionally present for some of her clients. This impacts on the therapeutic relationship, as she hopes the next client does not arrive. This may lead to temporary depersonalization of the clients; this experience may also impact on Brianna and her own feelings of personal accomplishment as she appears to be experiencing incongruence with her thoughts. Evidently, there is a strong link between the themes and extract 22 reflects this.

Super-ordinate theme three- Organizational support

<u>Superordinate sub-theme 3a. Supervision and time for reflection</u>

All participants commented on the importance of supervision in their role: for nine participants supervision was insufficient; it was not what they expected, and they need more depth and support from their supervision. These three aspects are present in the accounts of each of these nine participants. This was a main difficulty in their role. Three participants commented on the benefits of supervision and the emotional support this offered them in being resilient and getting through difficult times.

In this study, supervision was consistently commented on, most reflections of this were negative, with a few positive remarks. The focus of the positive remarks was on the quality of the supervision, and the negative remarks were around the frequency of supervision. Supervision was viewed as important and helpful, however, there was not enough time in supervision to take each client, therapists had to, therefore, choose based on risk or complexity and not take those who were relatively less challenging. Tessa shares a reflection that links organizational support to supervision, and lists supervision as a resilience factor against depersonalization and burnout.

> *[23]. Tessa: so I think we're really good at this service at giving praise and sharing positive feedback and things that come in, the supervision groups are always really supportive, I think our management team are quite strong and I think that helps again to get that feel valued and umm I find that really helpful kind of to acknowledge. Umm the accomplishments I guess that you make, because again it's not always easy to do that yourself when you're just seeing people day in day out so sometimes it is really helpful when other people do that for you. Umm and yeah I think just continuing to develop gives you that, it's kept my passion I guess for the role because you're always wanting to think more about things and think how things can improve and think about how I can improve as well and I think that stops you staying static I guess and just again we depersonalise or just burnout I'm always kind of looking for moving forward as opposed to just staying where I am I suppose.*(Tessa, 1235-1248).

Susie described having a supervisor who was a clinical psychologist and was her only source of support.

> *[24]. I think I'm lucky in this service because we have a really good clinical psychologist (*Interviewer*: ok) I didn't find other people to be that supportive and this is well another reason I thought I'd do the research! Because I think that's quite important* (Susie, 138-148).

Susie was both keen and open in her interview. She appeared to value the opportunity to reflect on the positives and negatives of the IAPT services; extract 25 offers further insights from Susie.

> *[25].* Interviewer*: ok, ok. And so what impacted on your decision to stop doing the PWP role?*
>
> Susie: *yeah, umm but* burnout, burnout that's why I thought I'd do the study*, I found that it was too many clients and not enough space in between and not*

> *enough supervision. Umm and I think I also got vicariously traumatised through some of the stories. (79-89)*

This extract is taken from the first few minutes of the discussion between Susie and myself, from the onset, she was passionate and open about her experience. She highlighted burnout as one of the reasons she decided to leave the role of being a PWP. Susie was very present and animated in the room as she reflected on the emotion, trauma, and burnout she experienced along with having minimal support from the organization and the limitations of supervision. She explained she was tearful, crying each night and could not function. Since changing roles, her situation had improved but she was now leaving the organization. On reflection, she appears the most comfortable with telling her story as she had nothing to lose or gain within the organization, as she was leaving shortly. Susie was accepted into a clinical psychology doctorate. Regarding IAPT she said, *'I have paid my dues I think'* (Susie, 365) suggesting that she wished to work in a more flexible therapeutic environment.

Susie, Brianna, and Tessa all discussed positive relationships with their supervisors, however it was interesting to note that none of these supervisors were traditional IAPT therapists. There were two clinical psychologists, one counselling psychologist and one counsellor who came to IAPT later in their career. Tessa explains that her supervisor's non-IAPT way of working is what has made her feel supported. She is open about her struggles and need for support and explains that when she has been impacted there are only certain members of staff she will go to.

> *[26]*. Interviewer: *How is that met, when you go to the supervisor because you are triggered?*
>
> Tessa: *() I only feel comfortable going to certain people because of, you don't obviously have relationship with them it does make a difference and it's about I guess knowing that you won't be almost judged for not being able to almost kind of handle it in a way and I sometimes feel that having worked in secondary care, come through to IAPT I think IAPT there's a lot more of a culture of just get on with it, just handle it you know move onto the next one just keep going.'*

In this extract, it is evident that the supervisor rota influences where Tessa seeks support. She names IAPT culture as one of endurance, '*just keep going' (182)*. There is a sense that within this culture she is concerned about being judged, the idea that the therapists are not expected to be affected by the stories clients share. Tessa speaks further on this and refers to it as '*lacking the permission to be human*' (393). Tessa has worked in mental health in secondary care and other settings and describes this difference as the nature of IAPT.

Subtheme 3b. Participants' experience of Training

All participants discussed the concept of training. Most had completed the post-graduate diploma in high-intensity cognitive behavioural therapy. Three of the participants, Brad, Stacy, Gwen were undertaking the high intensity training at the time of the interview. Mary was completing training as a psychologist. Derrick, Brianna, Chris and Susie had recently completed training in the last two years (CBT training and suicide prevention training respectively); while others reflected on their more general experiences of training. Brad, Stacy and Gwen were employees of the same team, and there were similarities in the challenges with training they each experienced. They were offered the training but the circumstances that were necessary for them to succeed at the training were not facilitated by their organisation. They were expected to retain the caseloads from their former roles, in surgeries and offered an afternoon to see the clients needed as part of their training. This made it difficult for them to practise the skills and have time to study and reflect. Gwen shares how the training has affected her.

> *[27]. I just don't have the energy really to umm to sort of create a good work life balance anymore. I'm just so focussed on my work, my studies and it does have an impact. My quality of life is certainly sort of negatively affected by it Interviewer: so you're, kind of prioritising the work that you're doing Respondent: yeah well I, I have to really and certainly as wellness I'm doing the training I think this is how it's going to be. Hopefully once I've finished the training there will be a little bit more scope for, for other activities as well and that will probably, probably help but right now it's quite tough* (Gwen, 75-92).

Similarly, another participant, Derrick who completed the course also disclosed experiencing a period of burnout at that time.

One striking experience of training was disclosed by Chris who had a few months off work immediately following some training. As he shared his experience he first described the impact on him as posttraumatic stress disorder (PTSD), however on reflection after reading about burnout he felt this was more reflective of his experience.

> *[28]*. Chris: *and the training course was quite traumatic actually.*
>
> Interviewer: *what kind of training were you going to*
>
> Chris: *it was the assist suicide train the trainer programme… because I've done the training programme and it triggered a reaction in me which I thought was maybe made worse by the medication from this because I wasn't sleeping properly but actually I've had some troubles in my domestic and personal life which of course have contributed to everything else.*
>
> Interviewer: *yeah, so it's like an interaction of things*
>
> Chris: *completely and when I meet a patient who's presenting with problems similar to what is going on at home it brings it on a bit more and a bit more. I hope I'm not being too flowery there but do you know what I mean*
>
> Interviewer: *no I think it's*
>
> Chris: *[28a] my professionalism is jeopardised (102-125).*

Chris is emotive and assertive throughout the interview. From the statement *'I have benefitted from talking with you… () because the more I talk about it, the easier it is…() you've stimulated some, quite a lot of thought for me'* (Chris-1726-1734) could be interpreted that he benefitted, from the interview and used it as an opportunity to process the experience. While suicide training can be challenging he reports he had done this training before. The delivery of the training had been changed and this affected him and other men on the training severely. He highlights in the extract above that it was a combination of this and his personal life that lead to his reduced professionalism and burnout. In my own double hermeneutic understanding of '*my professionalism is jeopardised*' [28a] I believe Chris means he is unable to give as much as he would usually to his clients, i.e. the quality of care is compromised. This might mean he is not present and his mind is focused on his own stress

rather than being there for the client. He may not be as therapeutically effective. On reflection, there was a deep sense of privilege to have been allowed to learn about his experience and witness his processing. Chris was barely out of his episode of burnout and had returned to work the week he was interviewed for this research.

Overall there was a sense that more training was needed within IAPT services and indeed that organisations provide more support for therapists when they are training. The training that many received felt insufficient when they saw clients. Mary, Tania, and Chris, two of whom were counsellors saw their training as a resource for reflection and a tool of resilience that they relied on in a complex working environment.

Subtheme 3c. Culture of endurance

All participants expressed experiences which were interpreted as of a dearth of support ubiquitous within the IAPT services where participants worked. Within the organizations, the culture promoted the acceptance that the work with clients and the environment was challenging, therefore, the staff were expected to be resilient and cope with this. This meant that support from the organization was at a minimum, if one truly struggled there might be the chance of some support if it was actively sought. This acceptance meant a more manageable environment was not being created.

Participants (Chris, Mary, Brad) used defences such as humour and metaphor to distance themselves from the emotions that arose as they discussed their experiences. The emotions appear to arise from negative social situations where they noted ill-effects on colleagues from the lack of support or recalled their own experiences. The participants overall all discussed organisational support and the lack of it. Two participants described it being a resource for them when they were struggling. One participant Brad with the use of humour and metaphor described how he saw his experience in the service.

> *[29]. so it's you can either run with it and do it or you burnout and you can't and it's a [29a] baptism of fire the service I work for umm where they basically throw you in at the deep end and you are, [29b] you sink or swim and that's how it works. I've been lucky enough to swim, I've found little techniques that I can do, little things that I incorporate into my day that allow me a little bit more space but that's self-management rather than service support which are two very different things* (Brad, 287-300).

'*Sink or swim*' reflects the dichotomous thinking characterised Brad's thinking and his own experience of the splitting within his team. People either sink and leave or swim and stay. The imagery of swimming and staying suggests a continuous battle. The metaphor suggests to me that the struggle is a rite of passage in the service. The intensity of the language '*sink or swim*'[29b] and '*baptism of fire*' [29a] captures the sense of being pushed to the edge of a cliff. These extreme descriptions are a representation of what he feels is an extreme experience.

Extract 29 highlights a sense of pride that is present for Brad as he can *swim* within an organisation that is unsupportive and challenging, where he observes others regularly failing. Brad's dichotomous thinking is evident throughout the interview. It offers a lens through which he sees the world. Beneath the overwhelming sense of pride were suggestions of supressed sadness for those who really were unable to survive the system. He described a split within the organisation, those who were liked, and those who were not, '*us and them*'. This was articulated by other participants from this organisation. Brad saw himself as in the in-group because he was a survivor, and this was strongly tied to his identity. He has accepted that the system is lacking in this kind of support but hoped for more support.

> *[30].* Interviewer: *so that sounds a bit difficult for a therapeutic environment to be in a therapy environment that that's very sink or swim, is that what you felt you expected when you went into this job area?*
>
> Brad: *no, you were hoping. See among my expectations were always wanting to be you know to be supported and there is support, we do have supervision, however, the supervision isn't adequate to a degree. You have one hour to review, I can see up to thirty clients a week you know, maybe less sometimes you know but I've less now I'm doing the HI training but if I'm seeing twenty clients a week an hour is not an opportunity to really offer me. I could spend 40 minutes talking about one those and*

so there isn't really enough space to be able to negotiate you know the difficulties we encounter in that sense so from a service perspective whilst they attempt to be supportive it's not adequate by any stretch of the imagination. (301-328)

Furthermore, he describes an occasion when he was off sick with stress and told his employer he had a cold.

[31]. Interviewer: *if you don't mind me asking why did you feel it wasn't ok for you at that point to cite stress?*

Brad: *because of the culture, because of that culture of you get on with it. You know you put up and shut up, sink or swim you know that that culture of you know thrive or don't you know you think ah I've got to keep going, I've got to conform to that and that's a dangerous place to be, it's an unhealthy place to be and I raised concerns about that and when I came back after having space then to think about things and thought this is not right you know (437-452).*

Brad changes from speaking in the first person to using 'you' which can be interpreted as distancing language. A typical example of this is provided in the following extract.

[32]. () *because of the nature of our roles, which is a lot of containing and a lot of holding of quite a high to a high degree I (had) a high degree of emotionally distress, you work with the emotionally distress every day, umm when it gets to a point where you can no longer contain, you can no longer function effectively as a therapist or as a line manager or a line managee, when you're struggling you know to get up and the motivation goes and anxiety creeps in and frustration and anger creep in* (Brad, 65-78).

This is a pattern that is evident throughout the interview; he often begins speaking in the first person and instantly shifts to the second person when he describes difficulties. Supervision is present but the time allotted is insufficient. He finds himself deciding which clients are most deserving of supervisory input.

Brad's insight and reflection is a representative view of most of the sample, nine out of ten participants have expressed similar views. Brianna offers a contrast to those views in that she feels the support in her current service is sufficient. Throughout her interview, Brianna compares her previous service to her current service. She shares that there is positive organizational support in this team and that it is one of the factors that has helped her.

[33].Brianna: *yeah definitely. It's such a different atmosphere and I think I really*

> *liked the team that I worked with but I think it was just so obvious that there was so much pressure coming from above umm so many people on long-term sick leave that I never kind of met you know over sort of, you know thinking that I worked there*
>
> Interviewer: *yeah*
>
> Brianna: *umm as well I can remember first, my first day here and coming in and people weren't you know running around the office and people were you know chatting and it was all quite, quite nice it. (338-346).*

Brianna reports an immediate culture shock, feeling that the organizational considered the staff and there was less pressure and stress in the atmosphere. Perhaps a breakdown in the community can be noted in the language used by the therapists interviewed 'us' and 'they' or 'them'. This highlighted the separatism that they experienced in the relationships with their management. In one team there was a noticeable division within the team of those who were liked by peers and management and those who were not, (or felt they were not liked), it was expressed by both sides and would contribute to burnout. Individuals reported a spilt in the team between who as liked by the manager and who was disliked. Being disliked by the manager then meant that they would not be liked by their peers. One possible interpretation of the findings is that the accounts from participants reflect the organisational factors that Maslach et al. (2001) linked to burnout.

Discussion

Introduction

This current research explored the experiences of burnout for ten IAPT therapists using semi-structured interviews. This section will present a conceptualisation of participants' experiences, linking the findings to existing research for a deeper understanding of the themes and experiences. My intention is that findings from this research will have value for the work of counselling psychologists and all therapists who work in IAPT services. The information can have practical applicability to line managers, supervisors, and commissioners. Improvements focused on therapists' wellbeing can result in a better service for the clients who are offered treatment in these services. The interviews deliberately focused on the three components of burnout, emotional exhaustion, personal accomplishment, and depersonalisation, as defined by Maslach and Jackson (1981). Each of the themes represented idiosyncratic but related experiences and at times a shared understanding among those interviewed. The themes were generated with an intensive IPA process. The limitations of the study and considerations for future research will be discussed.

Overview of the Findings

The findings of this study described the experiences of burnout and stress among ten workers in IAPT services. Therapists' wellbeing was significantly impacted by the challenges they experienced as part of working within IAPT i.e. their emotional, mental and physical health were adversely affected. Participants expressed concerns about the sustainability of the way in which they worked (i.e.) seeing high volumes of clients, paired with limited supervision and challenges in the therapeutic relationship. They experienced colleagues being off sick, and some had time off themselves related to burnout and stress. There was high turnover reported in the teams, for instance, three therapists in the sample had changed organisations within IAPT and a fourth to non-IAPT mental health service. Training, supervision and time for reflection

were discussed as factors that mediated the experiences therapists had within the IAPT services.

Therapist Wellbeing

Theme 1a. Therapists' emotional, mental and physical health and resilience

All participants described the emotional impact they experienced as a result of their work in IAPT. The results section of this current research highlighted Stacy and Gwen, who respectively expressed feeling '*depleted*' (Stacy,64), '*exhausted*' (Gwen,423) and Brad who stated that there is a distinct experience of this exhaustion that is particular for psychological therapists. This experience of emotional exhaustion is considered a component of burnout (Maslach & Jackson, 1981). When therapists experience a reduction in their psychological resources this may impact on the therapeutic relationship and their therapeutic effectiveness with clients. Extract 1 discussed Brad's distinction between burnout in a therapist and in another profession where emotions are not as essential for the role. This highlighted the importance of factoring this resource (emotions) into the number of clients seen by the therapists in this study and the need to consider the characteristics of their caseload (e.g. complexity).

IAPT therapists are strongly encouraged to strive for unrealistic recovery rates that put additional pressure on them when they are often working with complex trans-diagnostic clients in a limited timeframe. Participants also experienced difficulties in achieving these targets due to the environments in which they worked. For example, Gwen, Brad, Chris, Stacy, and Tania often worked in drop-in clinics, where clients self-booked appointments. Many of the individuals who booked into the clinic were not suitable for the service being offered, due to a lack of screening for suitability, but the therapist had little influence on how these service resources were used and who they saw. The complexity and way of working in the drop-in clinics made achieving the targets even more of a challenge. In the literature review, much of

the work of Maslach, a leading professor of psychology renowned for her research on burnout was presented. Maslach and Leiter (1997) focused on the social environment and highlighted six factors: work overload, insufficient reward, a lack of control, and unfairness, the breakdown of community and value conflict as environmental factors that impacted on burnout. Work overload is reflected in the high caseloads that therapists are expected to see in IAPT services and the unrealistic recovery rates they are expected to attain. They may also experience a lack of control over their circumstances in the drop-in clinics, where clients are not suitable. Arguably, these social and environmental factors contribute to the experiences of depletion and exhaustion described by Gwen (423) and Stacy (64).

Next, the theme of mental health was discussed by six participants. In Extract 2 Chris discussed his experience of Post-Traumatic Stress Disorder and burnout. He felt these were strongly impacted by a combination of personal stress, training, and work. The mental health symptoms of burnout were evident here, for Chris. These results can be supported theoretically by the interactional model of occupational stress (Osipow & Spokane, 1984), which argued that there is an interplay between the work role and the individual's ability to cope with difficulties within the work place. This is applicable to Chris whose coping resources for detailing with his difficulties at work were significantly impacted by a parallel struggle within family life for example, the health of his daughter. Stress is a component that can lead to burnout; as stress builds the individual becomes more susceptible to burnout. Therefore, as Chris experienced stress from various sources, both personal and professional, this can be seen as a significant aspect of his burnout.

The findings of this current study can be related to Steel et al. (2015), *Exhausted but not yet cynical,* which found high (as defined by the MBI manual) levels of Emotional Exhaustion among the 116 participants sampled, who were all therapists working in IAPT, but had low levels of Depersonalisation. That study was conducted in 2012 and highlighted that

the correlation suggested a gradual increasing relationship between Emotional Exhaustion and Depersonalization and as most of the sample were early in their career there was an anticipated trajectory of further Depersonalisation in the future. This current research which was sampled in 2016 reflected a sense of cynicism and some Depersonalisation towards clients. It was also evident that supporting Steel *et al.*'s findings Depersonalisation was experienced more by participants in this current study who have worked in mental health and in IAPT for a longer time, in comparisons to Tessa and Brianna, who were recently qualified and much more positive and hopeful. As highlighted in the results section other factors may affect this experience such as the levels of support from the organisation.

Next, physical health components of stress and burnout were expressed by the majority of the participants. All of the three men interviewed focused more on the physical symptoms of their burnout whereas the seven women interviewed shared more details about their emotions. Women began discussing emotions first and centred their discussion on the feelings associated with burnout rather than their physical experiences. This may be more typical of the differences in how the genders and individuals experienced their symptoms and can be related to the narratives that individuals have about their experiences and the interpretative and phenomenological nature of their experiences. For example, for Chris, his narrative was that he was physically unwell, suffering from a chest infection when he began to notice his hallucinations. Perhaps this fed the way he understood his symptoms initially, based on a medical model. He was also open to understanding his experience as PTSD and burnout and began to read literature on wellbeing to help him understand what was happening to him. This is evident in extract 2 in the Results (Chris, 91-99).

The differences in focusing on physical or mental health were not the only interesting factor in the way participants chose to share their stories; their choice of language was also important. The use of language might be a mechanism that the participants used to avoid shame

around these experiences (Cheston, 2005) or emotional distancing (Nathanson, 1997). One example of this is Extract 13 where Brad begins to use distancing language and he discusses his difficulties with being able to maintain the role of being a therapist within these constraints. He describes feeling angry and frustrated, and his sense of shame is conveyed in his emotionally distancing language; there is a conflict for him in feeling these emotions. Another example is the use of humour, which was used throughout the interviews as a mechanism of avoidance, one participant Chris described experiences in abstract metaphors rather than using concrete descriptions directly related to his own experience. He often used statements like '*I'm quite old fashioned'* (laughs) (1041), while discussing deep aspects of his burnout and experiences while being off sick. Another reference from Chris' use of language as a barrier from emotion occurred when Chris changed the direction of the conversation and began discussing his values more generally rather than related to burnout e.g. '*brick wall going up towards Kentish Town and somebody had sprayed on it years ago, my karma has run over my dogma. That's one of my mottos*' (1111). Here it appears he pulls back from his emotions, to allow himself to process his thoughts, cope and continue with the interview.

The link between emotional, mental and physical health and resilience invites us to think about the interaction of individual traits and systemic causes of distress. A possible interpretation of the data collected, that fits with the idea that burnout is an individual and systemic problem, is that some individuals are drawn to this type of role due to their own mental health difficulties which can be related theoretically to the '*wounded healer*' archetype that is present in literature (e.g. Zerubavel & Wright, 2012; Amundson & Ross,2016). The wounded healer describes individuals who have been impacted by difficult experiences in their own lives and were drawn to the therapy profession because of this. This does not suggest that the therapist is flawed, rather, their experience of their own story and experience of client stories combine to help with professional development and wisdom (Blates & Smith, 1990). This is

often an asset as it offers insight, self-awareness, and traits that would be helpful for the role. In the results, extract 3 highlighted the existing anxiety difficulties present for Brianna, and the way her wounded healer narrative drew her to the role. Indeed, her experiences may have been an asset and provided empathy and understanding for her clients. However, Gwen and Tania, described their low mood as being a product of the environments in which they worked. Richards, Holttum and Springham (2016), explored the relationship between being a mental health professional with the experience of having been a mental health service user and the social constructivist distinction that occurs between a professional identity and a 'mental health patient' which sometimes carries a pejorative meaning. Richards *et al.* (2016) commented that the wounded healer is sometimes seen as less professional than other therapists. From the presentation of competent and insightful reflections such as Brianna's it can be argued that being a wounded healer has been an asset for the therapists interviewed.

My interpretation of the emotion, mental and physical health and wounded healer narrative is that it relates to the idea and theme of resilience. Whether a participant is wounded healer or they are impacted on these three levels (emotional, mental, physical) by their work environment or not experiencing burnout, there is still an opportunity to consider their resilience. Psychological resilience refers to the individual's ability to remain psychologically robust in the presence of adverse experiences (Bonanno, Westphal & Mancini,2011). Leipold and Greve's (2009) definition involved the ability to quickly bounce back after adversity and this is what it represented for Brianna and Tessa, who discussed working on their resilience in a positive way. Within the interviews, therapists shared a view of resilience that was multidimensional and linked to various factors similar to the research of Bonnano (2004).

Brianna was optimistic or reflected positively on her current role, compared to her last role in another IAPT team: '*you know I think there's much more flexibility*' (944). Optimism is a key tenet in resilience, referring to the individual's belief that good things will happen to

them in the future. This is a tool that can be cultivated and thus increase psychological resilience (Carver, Scheier & Segerstrom, 2010; Fresco, Moore, Walt and Criaghead, 2009). Increase in optimism can impact psychological wellbeing, result in better physical health and coping strategies, which are areas shared as being significant within individual's interviews. In the example offered by Brianna, her previous IAPT role exacerbated her perfectionist traits, however a change in environment and perhaps personal development have helped create a positive shift in her thinking and wellbeing. Optimism can be developed within individuals in line management, supervision, organisational support, and offering individuals opportunities to influence their work environment.

Furthering the argument above for the balancing of personal life and work life, this balance also impacts on resilience. Participants suggested that they could manage well when one of these areas was disrupted but when both were difficult burnout and intense stress occurred. Brianna, Gwen, and Brad stated that often their personal lives were significantly impacted by their work, highlighting the fluidity of these boundaries and their effect on each other. This phenomenon is reflected in research presented in the literature review by Paine (1982) and Ackerley *et al*., (1988) who suggested that personal relationships and ineffective coping skills contribute to burnout, relationships impact on work and can be impacted on by dysfunction at work. It can be argued that work-life balance and coping skills can worked with to reduce the impact of burnout.

Resilience can also be built by adapting the expectations that practitioners and organisations carry. Therapists can be offered the same levels of compassion and acceptance that is offered to clients. Due to the emotional resources that are necessary for the role, there needed to be systemic and individual self-compassion and consideration of self-care offered to the therapist, to help them give the warmth and empathy needed in a therapeutic relationship. According to Lankford (2012), the individual's drivers can be adapted to form an antithesis,

for example, drivers such as 'Be perfect' can translate to 'be human' or 'be strong' to 'feel your feeling and still relate effectively.' An example of this drive for perfectionism has been shared by Brianna '*where I do have the tendency to you know be, I suppose not so much now but I think (when) I get stressed, more perfectionist I think, I end up wanting to like book more and more people in and then actually not thinking about how unrealistic*' (847-953). The definition of being human refers to noticing when perfectionism cannot be achieved and rather than being stuck at an impasse, accepting that the individual, has sufficient resilience to thrive and have a positive experience with plan B. For example, relevant to Brianna's example, therapists may see the ideal outcome as helping clients with various interrelated difficulties, looking for a holistic recovery before ending therapy. However, in time-limited work such as IAPT, this is not always possible. Not accepting this might mean the therapist experiences a lack of personal accomplishment. There is also the likelihood that several areas of difficulty are opened for the clients and the obstacle of time becomes more pronounced in the relationship. However, acceptance of the boundaries of the work can lead to a beneficial experience for the client and the therapist.

As expressed in the literature review coping strategies are a significant part of resilience and burnout. There were few references to these among the individuals interviewed. This perhaps reflected the overwhelming experience of burnout participants experienced and their feelings that their coping skills were limited. Social support also impacts physical and mental health. Brianna shared her experience of moving away from her social support and this being, on reflection a contributing factor to her experience of burnout. Participants interviewed often stayed late at work to complete tasks which meant poor work life balance. In my opinion this links with McAuley's (2010) research which showed that therapists working in IAPT often do not use rational or cognitive coping skills despite it being their main area of practice.

Subtheme 1b. Participants' ability to stay in their roles: Sustainability

The theme of sustainability encompasses sickness, varying degrees of burnout and turnover. Participants, (e.g Tania, Gwen, Brianna and Brad) held beliefs that changes, such as more time for administration, and role diversification (e.g. providing supervision) could help them enjoy their role more. So, some sought diversity within the role and others looked for employment in other IAPT services or other mental health services. Clark (2017) highlighted the 21% annual turnover rate in Psychological Wellbeing Practitioners in IAPT services across the UK. It was interesting, on reflection that despite their experiences, none of the participants disclosed an interest in seeking out non-helping or non-therapeutic roles. It appeared that participants still wished to be therapists despite the challenges. This might suggest that there was a level of commitment to mental health and that participants continued to hope that changes to their day-to-day job tasks would make their experiences more manageable.

As highlighted in the results, many therapists and other colleagues had frequent periods of sick leave related to burnout. It impacted on morale, and for Brianna, increased her focus on keeping well. Brianna attributed her colleagues being off sick and her own sense of feeling pressured to an environment that was target focused '*just the amount of pressure, it felt there was from above to kind of meet targets and felt like everyone was talking about targets a lot of the time and yeah*' (Extract, 7, in results). Brianna appeared to really respect the people about her, so seeing them struggle and be off sick themselves impacted on her, it seemed to add weight to the pressure Brianna experienced. The targets had a negative impact on her wellbeing as they activated perfectionist traits and made her feel she was not a good enough therapist. At the time she lacked social support and the lack of organisational support or a positive sense of community were detrimental to her. It is evident that these factors contributed to her leaving her previous IAPT team and rectifying some of these by joining a new team and re-engaging with her social support lead to more sustainable employment within a different IAPT service.

Various characteristics such as contract type, and experience as a therapist were discussed, in the interviews, in relation to stress and burnout. Amongst the people interviewed, it appeared that many saw a significant difference between working part-time and working fulltime for a therapist in IAPT services. Being part-time or full-time affected participants' perceived levels of burnout and their own perceptions of their ability to cope. Five participants discussed the difference; the cohort interviewed expressed this as one of the areas that impacted on how long a therapist was able to maintain their career.

Age and length of time participants have worked in mental health influenced the experience of burnout among the therapists who were part of the study. To be clear, my argument is not that younger therapist are more susceptible to burnout, rather that a combination of factors impacted on each of the individuals interviewed, such as age, experience and part-time or fulltime work. It was evident that there was a disparity between the experience of Brianna and Tessa who had worked in IAPT for four and two years respectively, compared to the other eight participants. They were positive about the system and the advantages that could be gained from role diversification. However, interestingly, Susie and Brad who had the same length of experience had more experience of burnout. My interpretation of this is that their experience was more influenced by the service difficulties and organizational culture (lack of team cohesion and support) than the number of years they were employed as therapists or in IAPT. Further examples of the impact of experience are seen with Gwen and Chris who had ten and fourteen years of experience and were deeply affected by their work and the interaction between work and their personal lives. However despite these severe experiences of burnout, Gwen and Chris were still in their jobs and continued to work, at the time of interview. My understanding here is that there are various factors such as responsibilities and having families to support, that may have impacted their decision to stay in employment, perhaps for stability.

It can be argued that having more pressures at home such as family and children or carer responsibilities, can be an additional mediator or trigger for stress. It is natural for these responsibilities to come with age; as people grow older they may have children and are more likely to have to care for older people such as parents. Within this study, Chris and Gwen discussed the impact of their personal lives on their role and vice versa. Perhaps age and personal responsibilities contributed to more *hardiness* (resistance in the encounter with stressful life events and individual's commitment to their role Kobasa, 1979) among these participants. Research indicates that older trainees have greater hardiness, than their younger colleagues (McAuley, 2010). However, age is also related to experiencing more stress in health care professionals (Kirkcaldy &Martin, 2000). Therefore, perhaps the interpretation of Chris and Gwen's experiences can be that they have more stress, however they may develop more hardiness traits to help them deal with stress. This furthers the argument that burnout is impacted by an interaction between both personal and professional factors. It is evident that individuals in any field of work are likely to experience some forms of personal stress during their career, therefore considering this adaptation and a supportive working environment would help to maintain the workforce. As noted in the results section, four participants described role diversification as one of the ways they can engage in self-care, considering the limitations of their emotional resources and this can be supported within IAPT organisations.

Sub-theme 1c. Personal accomplishment

This theme was viewed as important throughout the interviews and individuals appeared passionate about it. Brianna in her statements highlighted in the results (511-521) and (671-686) suggested that her feelings about herself and her role are strongly tied to feeling competent at her job and feeling like she is excelling or at least perfectly meeting the minimum standard. Tessa in Extract 9 of the results section, discusses '*I give a bit more of myself*' (9a) and '*but I'll end up very stressed at the end of that day*' (9b). One interpretation of these

remarks is that she is very stretched, with seeing clients, but as her sense of personal accomplishment is so strongly tied to completing good work and supporting her clients, she stretches herself even further into emotional exhaustion to meet this sense of fulfilment, which then leaves her feeling stressed. It appears she may be experiencing a psychological dilemma. In many ways there seemed to be a tenuous match between these individuals and the environment in which they worked. Person environment fit theory, is another theory (like the international stress model discussed previously), which describes the interaction between the environment and the personality characteristics of the individual (Lewin, 1935; Murray 1938). These characteristics impact on their cognitive, affective and behavioural responses, i.e. Brianna evaluated herself on her feeling of competence, despite her awareness of the constraints of her role and Tessa overextended herself.

The theory of person-environment fit suggests that if the workload exceeds the individual's time and energy constraints, then there is the potential for increased psychological strain. In a system such as IAPT that is focused on high volume, with therapists staying later than their contracted hours, working during their lunch breaks and seeing clients back to back, the time and energy are influenced in a concrete way that affects performance, wellbeing, and sustainability. When reflecting on the perfectionist traits Brianna shared, when she worked in an IAPT service where people in the team including the managers were stressed and very target focused she really struggled. In extracts 11 and 12 her feeling of a lack of personal accomplishment are shared when she states '*am I just rubbish at my job*', she also reflects on the environment in there therapeutic organisation in which she worked '*I think our managers were so stressed themselves…we weren't communicating in a you know perhaps very therapeutic or understanding way with each other*'. These statements reflect how much emotion Brianna was holding at the time, she was very stressed, feeling there was not support accessible in the organisation and lacking personal social support, which led to a stress and

burnout experience for her at that time. However, she has changed teams and reconnected with her social support and she has found it more manageable.

Caseload Challenges

Inherent in working in IAPT services, therapists are expected to see a high volume of clients and are encouraged to be target focused. There are difficulties associated with a high caseload such as a drain on one's personal emotional resources and this impacts on the individual's resilience and increases the possibility of stress. These areas will be discussed in relation to various theories, in this section.

Sub-theme 2a. High caseloads and complex client presentations

Complexity and high caseloads were two of the most discussed areas in the interviews. Derrick, Susie, and Brianna discussed their struggles for balancing the needs of a complex client group with the number of people they had to see. This experience appeared to have led to feeling of stress related to burnout for all the therapists interviewed in this study.

The impact of complexity on stress can be understood in relation to psychological theories of stress, which have changed over the years, some viewing it as various components, a process or an experience. Stress is a transactional process between the individual and the environment (Lazarus, 1991). Burnout incorporates factors of emotional exhaustion and as Lazarus and Cohen-Charash (2001) suggest '*stress and emotion should be treated as a single topic*' (p.53). The transaction theory of stress fits well with the current research questions and exploration of experience in the current study. The results of this IPA study are focused on meaning, and in keeping with this, the participants' experiences were analysed based on a relational or phenomenological stance which is also inherent in stress or burnout as phenomena. Transactional theory suggests that the appraisal that the individual gives to the experience and environment, coined '*relational meaning*' (Lazarus, 1999, p. 96) is how one can understand

how the individual may come to experience stress, based on the meaning they attach to their experience.

While stress is generally seen as a negative phenomenon, it is well documented in the literature that positive stress or eustress can have a motivational impact (Bartlett, 1998; Amabile, Barsade, Mueller & Staw, 2005; Seligman & Csikszentmihalyi, 2000). However, the amount of stress experienced by Brad, Gwen, and Chris meant they could not manage their personal lives as well as they hoped. For Chris when additional stressors became present at home, he experienced severe burnout and went on long-term sick leave. Perhaps this is an example of an additional stressor than leading to faster and more pronounced exhaustion according to Seyle's (1967) theory. Seyle's theory is biologically based, and it argues that when a stressor is added the body's resistance drops then rises, and this cannot be sustained and then leads to exhaustion. He stated that if a second stressor is added the state of exhaustion is reached more quickly. This is reflected in the experiences noted in the therapists' interviews. For example, extracts 15 and 16 discuss Derrick and Tania's awareness that there were not any services suitable for the more complex clients, therefore they needed to work with limited resources, this pressure would have added to the stress they experienced. While the model has received criticism for illustrating a static progression, it does provide insight into the development of exhaustion, which is integral to understanding the experience of stress and burnout. According to Lazarus and Folkman (1984), this model overemphasises the physiological aspects of stress and underemphasises the psychological. While they are linked, the argument here is that stress is a precursor and element of stress.

Subtheme 2b. Participants' experience of the therapeutic relationship

For the therapists the quality of the service they provided, and their relationship with their clients were paramount, and consequently all ten participants discussed it. Therapists are often pulled to careers in helping roles because of something innate in them. Even outside their

professional roles they may find they are often the friend or family member who is a good listener or problem solver. This same drive and interest to help others means that self-care is often left off the agenda. Noted in the Results section of this study, Chris, Brianna, and Derrick discussed experiences that made them feel drained and '*not fit to practice*' (Derrick, 624-525). The high caseloads would have impacted on the emotional resources of the therapists. As therapists working in IAPT services are seeing a high number of clients within their work week the caring cycle is important to consider (Skovholt & Trotter-Mathison, 2011).

Skovholt et al. (2011) discussed the difference between burnout and caring burnout, meaning that burnout in the caring profession impacts the individual differently than burnout in other professions, as there is more of an emotional impact. The cycle of caring stems from the process described by Bowlby in his books *Attachment* (1969), *Separation* (1973) and *Loss* (1980). Within the caring cycle, there is the need for the practitioner to use common factors such as empathy, genuineness, and interest to facilitate the therapeutic relationship with the client. There is an optimal level of attachment that therapists should strive for (Skovholt et al., 2011) and the polar opposites of the spectrum might mean less than ideal therapeutic outcomes. In this study, the therapists have expressed taking their work home with them mentally. This can then impact on them emotionally, with them becoming overwhelmed and frustrated. These experiences reflect a breakdown in the caring cycle with the therapist carrying a lot of empathy that leaves them feeling depleted.

Several therapists reported in their interviews that they reluctantly wished that their next client would miss the appointment. For example, in extract 18 Brad described, his wish that the next client would not show up, so he could have a reprieve. Participants stated that these thoughts were because they felt emotionally tired and drained. Drawing on the caring cycle and the need to form attachment in each therapeutic hour, one can ascertain how the depersonalization and attachment interact in the process that is burnout. The caring type of

burnout occurs when the therapist is unable to or struggles to form the types of attachments they need to with new clients Skovholt *et al.* (2011). This extant research can help us understand that this cumulative depletion may be attributed to the use of the self with the relationship and that each encounter can contribute the exhaustion and depersonalization expressed in extract 18. However, when work is actively engaging and enjoyable, the therapist may experience satisfaction, which Skovholt et al. (2011) describe as being opposite to the cumulative depletion that occurs in burnout. For the ending the therapists have with their client may either invigorate and aid in the development of a new caring cycle or impede it (Davis, 2008).

The therapeutic relationship relies on the therapist creating a safe emotionally sound space for patients to discuss their difficulties, therefore if burnout leads to drain on these resources it also impacts the therapeutic relationship. Hence within a therapeutic role, it is important to consider the value of the therapeutic relationships and how this links to the practitioner's own emotional resources and wellbeing. Evident in Extract 22, Brianna shares her own difficulties when she sees more than five clients a day. From this we can discern that complexity, time and number of clients all need to be considered for her as factors which affect her therapeutic relationship with clients and her own wellbeing. It is noteworthy that this is a view shared by all of those interviewed. Therefore, while results from this IPA study are not expected to be generalizable, they may be helpful for reflection and consideration in services or further research, and perhaps further quantitative research.

It has been evident that there is fluidity and connectivity between the themes discussed throughout this research. There is a connection between personal accomplishment and the therapeutic relationship. As the individual struggles with their caseload, they experience a depletion of their personal resources and detachment from clients, this then impacts in a

cyclical manner on their view of the therapeutic relationship and in turn their view of themselves. Organisational support will be discussed next.

Organizational support: Supervision, Training and Culture

Clinical Supervision

Therapists in the study felt they needed more time, supervision and training to work with their clients. This was influenced by the complexity of the clients who presented to the service. National guidance (e.g., DoH, 1993) has highlighted clinical supervision as a method through which management and reduction of staff burnout can be achieved. Similarly, Sutton (2015), in an unpublished doctorate thesis, evaluated the relationship between supervision and burnout in mental health workers in a medium secure unit. The results of Sutton's study showed that attending clinical supervision reduced the likelihood of burnout, albeit in a different context. It is also effective and appeared to result in the reduced experience of burnout, for those who were already identifying as experiencing burnout. Sutton's study is relevant to the current research which offers a qualitative perspective on primary care. Sodeke-Gregson, Holttum, and Billings (2013) also noted in their research on compassion satisfaction, burnout and secondary traumatic stress that perceived organisational support and supervision contributed positively to participant wellbeing. Similarly, Miller and Sprang (2017) created a practice and supervision-based model to reduce experiences such as compassion fatigue and burnout among practitioners who work with trauma.

The participants of this study have explained that they are inefficiently supported by the amount of supervision they received. Many different theories and models illustrate the importance of supervision. Several supervision models discuss the benefits of considering the emotions and experiences of supervisees. One such model is the Hawkins and Shohet (2012) model of supervision, which has discussed burnout and organisational support. Several participants (Chris, Susie, Tessa, Brianna, Stacy, Brad and Tessa) commented on the restorative

properties of supervision and their need for more time. Time limitations meant that they had to use only one of the functions of supervision, the normative or administrative case management and were left without the other benefits, formative (education) or restorative (support) (Proctor,1987). Effective supervision and best practice would allow the participants adequate time for supervision regularly and contingencies for further support when working with complexity. Arguably, each of the functions impact different outcomes in terms of professional accountability as well as the social support function that can help reduce burnout and increase individuals' ability to cope with their workload (Brunero & Stein-Parbury, 2008). When the normative, formative and restorative functions are considered they can reveal relationships between emotional exhaustion, depersonalization and personal accomplishment (components of burnout, Maslach). Supervision can allow the therapist to process their emotional experiences, so they are not left holding all the responsibility, as there is a shared responsibility in the supervision. As they discuss their emotions they can reflect on their work with clients and gain valuable insights to apply to further sessions. The formative function helps to develop the therapist's skills and make them feel competent; if this function is facilitated this may have a positive impact on emotional exhaustion and personal accomplishment. The restorative function focuses on support and can positively impact the three components of supervision. The need for the restorative function is aptly described in Extract 20, of the results section, by Brad who stated:

> '*it gets to a point where you can no longer contain, you can no longer function effectively as a therapist or as a line manager or a line managee, when you're struggling you know to get up and the motivation goes and anxiety creeps in and frustration and anger creep in'* (65-78).

Brad's difficulties with processing and holding these emotions after seeing several clients can be positively impacted by appropriate supervision that allows for all functions to be explored. Evidently Brad shifts from speaking in the first person as he begins to describe

burnout, he creates distance by using the word '*you*', this suggests that this topic was difficult for him to discuss.

According to the participants, regular and emotionally supportive supervision is seen as an important prevention factor for burnout. As the functions of supervision (Proctor, 1987) may relate to prevention of burnout, it may be helpful for supervisors to receive training in how to offer the best for their supervisees. Gazzola, De Stefoano, Theriault, and Audet (2013) have highlighted that supervision training is a relatively recent undertaking. Training and Continuous Professional development (CPD) can help supervisors to be aware of specific models of supervision which they can then use to facilitate supervision that effects these important changes. Supervision has been suggested as an intervention through which burnout can be alleviated (Clegg, 2001; Edwards et al., 2006). Therefore, there is a need for more training for supervision in IAPT services. The most common practice is for a therapist who has had a few years' experience to offer supervision to others, however training in the models and processes of supervision can lead to a more beneficial relationship and professional development for the supervisor and supervisee. While psychotherapy training is often used as evidence that a therapist can offer supervision, this has been critiqued (Bernard, 1981). Several researchers have pointed out the difference between therapy and supervision and the theoretical bases that support them (Ladany, Friedlander & Nelson, 2005; Dartnall, 2013).

It is interesting that the participants who commented positively on their supervision stated that their supervisors were not IAPT trained or were clinical or counselling psychologists. In my opinion, this supports the ongoing professional debate regarding more involvement of the British Psychological Society in the accreditation of CBT therapists and governance of IAPT training. As Dr. Tony Ward suggests in *The Psychologist* letter 'A call to arms' psychologists have a lot to contribute to IAPT (Ward, 2008). Supervision and training in

various models of therapy are some important examples which can contribute to positive changes in IAPT.

Recent research by Westwood, Morison, Allt and Holmes (2017) explored the predictors of burnout in IAPT services. They administered the Oldenburg Burnout Inventory (OLBI; Demerouti, Bakker, Vardakou, & Kantas, 2003), to 262 participants (IAPT therapists) in the South of England. Their findings showed higher measurements of disengagement on the OLBI (similar to depersonalisation) among PWPs. Clinical supervision was considered to be linked to lower levels of disengagement. For PWPs increased hours seeing clients, length of time with the current service, inputting data and overtime increased the likelihood of burnout. In this study the need for more supervision was discussed by all therapists, reflecting its importance. Susie, in extract 23, of the results described supervision as her only source of support '*I think I'm lucky in this service because we have a really good clinical psychologist () I didn't find other people to be that supportive*' (Susie, 138). This quote reflects the ways in which support is offered at an organisational level and the importance and impact of good supervision.

While supervision is beneficial for holding a reflective space, beyond this, participants needed time before and after clients to sit with themselves and think about the clients and prepare for their sessions (e.g. reviewing notes and treatment plans). This contributes to more effective practice and interventions. One example of this from the results relates to the need for more time when working with clients with complex presentations Susie (153-160) and Brianna (450-479).

Training

Training has been thought to be a precipitating factor affecting stress and strain in mental health professionals (Cushway, 1992). Chris shared his experience of this, in extract 32, in the Results section. Gwen shared how the training has affected her; she has accepted that her

training would be a challenging time and her personal life would be negatively affected. Evidently, the pressure of the work and training became overwhelming for these participants, as they are not allotted the time they need to study and the reduced caseload or work-related tasks.

There is a split in the field as to the solutions and ways to manage this (Truell, 2001). Some suggest that mandatory personal therapy might be helpful (Clark, 1986; Macran, Stiles & Smith, 1999), while others disagree (Greenberg & Steller, 1981). However, there continues to be mixed views by trainee therapists (e.g. counselling psychologist and psychotherapists) who have had mandatory therapy as part of their training (Murphy, Ifran, Barnett, Castledine, Enescu (2018). In most IAPT training institutions personal therapy is not offered or recommended as part of their training. The programs are intensive having been compressed into a shorter time span to allow for more time efficient training of therapist to meet the demand. In related training fields like counselling psychology, personal therapy is part of the training requirements. When this is part of training it may help build resilience and help therapists view it as a resource later.

A culture of Endurance

In many ways the training, minimal levels of supervision and space for reflection contribute to the generation and maintenance of a culture that does not prioritize wellbeing. Rather such a culture places the onus on the individual to persevere and endure challenging environments. There is existing evidence that targets within the NHS adversely affect the wellbeing of the staff (O'Reilly, 2010). Reflecting on Extract 23 it is evident that Brad has internalized the culture of the organisation, and even when unwell he is aware that there is a social expectation to put clients and the role first. It is curious that this culture has developed as there is evidence within the field of therapy that individuals need to be well themselves to provide best care (Moore & Cooper, 1996).

This current study showed that negative relationships at the workplace contributed to more psychological distress; this link can be made with several of the experiences of those in one of the teams where participants worked. Conversely, others described themselves as having a positive relationship with those above them and reported more resilience and a likelihood to remain with the employer. As there is a culture of endurance within the services where some participants worked perhaps then social support could be factor that could help individuals to cope in these challenging environments. In a similar field where police officers were in a helping role and exposed to traumatic experiences, social support led to experiences of less psychological distress (de Terte et al., 2014). This may help participants with their work with clients and the organisational challenges. Additionally, supervision maybe a useful tool to help support individuals with the challenges they experience in their working environments.

Several articles on stress and burnout (e.g. Walklet & Percy, 2014), while acknowledging the organisational factors that impact therapists, still mainly focus on the individual factors as a means for change, stating that organisational change might be '*unrealistic*' (Walket & Percy, 2014, p23). It can be argued that this unconsciously reinforces that culture, or reflects how deep and wide spread the acceptance and endurance is. Indeed, even though the importance of making change at an individual level should not be ignored, this should not be at the cost of recognising the need for broader, systemic or organisational-led improvements. A view shared by Maslach et al. (1997) and Skovholt et al. (2011) is that while there are issues within organisations, it would not be wise for practitioners to wait for employers to drive initiatives of self-care. However, there is a cultural change that needs to occur, where self-care is not seen as a time-determined luxury but an integral part of the work, which will aid in the prevention of burnout (Barnett, Johnson, & Hilliard, 2006).

Implications for practice

Implications

This research has highlighted the challenges of high caseloads, limited time for supervision and reflection, which are organisational factors which affected the experiences of burnout for these participants. Individual factors such as resilience and personal circumstances were explored. Therefore, interventions need to address both areas to be effective.

Interventions to prevent burnout should be discussed as being an important part of training. It is often given some attention in training programs but not made a feature in a significant way, in relation to its importance. Interventions related to the six aspects of social and environmental factors described by Maslach et al. (2008) include efforts to counteracting these conditions. For example, they advocated for implementing a sustainable workload to prevent work overload and help counteract lack of control by promoting opportunities for control and choice. Action at the organisational level on these six aspects can help create a better environment and less burnout.

Therapists' reflection on their own reasons for being engaged in therapeutic work, has been viewed as one way to maintain resilience and sustainability in the therapeutic environment. It is recommended that practitioners develop their resilience with new knowledge, creative ways of thinking, new ideas and experiences. This might look different for different therapists; for some it might be reading books, others special interest or reflective practice groups. Interventions to build resilience and hardiness can be helpful in reducing rates of burnout and stress in IAPT. According to McAuldey (2010) and Maddi (2002) this training can be beneficial to primary care staff, increasing work performance, job satisfaction, and health.

Skovholt and Trotter-Mathison (2011) suggested that reflection cannot thrive in environments that are volume driven and that this might only help reinforce the status quo and

cognitive patterns. While practitioners can be part of developing the reflective programs and help shape them in a manner that works for them, both the therapists and the organisation would need to view reflective programs as part of the role being added in addition to client hours therefore being appropriately factored into the structure of the working week. Essentially while therapists can help to create such programs they still ultimately need the support of the organisation.

Often therapists hope to help patients recover from all co-occurring difficulties. It might be more helpful to limit one's expectations, taking pride in small changes, working on one presentation as a course of treatment. This would be beneficial for the client and for the therapist whose personal resources need to last them for the length of their career. It also helps both the practitioner and therapist have a view of more realistic recovery.

Personal therapy was traditionally seen as part of training programs for those in mental health therapeutic practices (Wampler & Strupp,1976). From early on some training providers disagreed, with the recommendation of personal therapy (Greenberg & Steller, 1981), and the debate is on-going (Truell, 2001 & Murphy et al. 2018). Personal therapy is seen as an integral part of some models of therapy but not essential in others. It is more common amongst exploratory or psychodynamic therapists rather than problem focused or CBT therapists. Perhaps therapy can be offered by the organisation occupational health to therapists if they require support.

Limitations of the study

The recruitment strategy was an opt-in method and that meant there was the possibility of response bias based on characteristics of the individuals who contacted the researcher. It may be likely that the persons who participated in the study were more likely to have experienced stress and burnout. One participant, Mary suggested that she participated in the current study because there were many people she was aware of who were experiencing

burnout and were unable to represent themselves. She felt that this might be because they did not have the time or resources as they were significantly affected. Considering this, it could be argued that the response bias might mean that the most severely impacted, such as those who were off sick at the time or had left IAPT, were unable to participate. This is supported by research by Barr et al. (2008) who suggested that individuals who perceived overload and stress in their roles were least likely to respond to the research. Alternatively, those therapists who were not experiencing burnout and not interested in it or who did not see it as relevant to themselves may not have chosen to participate. However, I am aware that such a critique is more applicable to a quantitative study. This study raises important questions about how widespread burnout is, and secondly it shows that when burnout takes place within IAPT services, this is what it looks like and these are some of the issues that it raises.

Sample criteria

Any IAPT therapist who had worked in an IAPT service for at least one year was eligible for the study. More purposeful sampling was considered, such as individuals who self-identified as having experienced burnout or who had left the service. The rationale for using this sampling method was that there would be benefits in terms of learning about the persons who did not identify as being burnt-out that might be helpful in understanding both the experience of burnout and those who were not experiencing burnout. A secondary rationale was the pragmatics of recruiting individuals who had left the services due to burnout and then the likelihood of a more significant response bias from such recruitment. Overall the sampling limitation was considered, and this approach was considered best fit for the area being researched.

Social Desirability effect

There are certain behaviours that are considered to be more socially acceptable than others (Dyer, 1995). Interviews are subject to social desirability as a limitation, which has been

considered in this study. Efforts were made to limit the effects of this, which included labelling the email invites as 'Burnout and Wellbeing Study' and noting on the flyer 'you do not have to have experienced burnout to participate.'

The impact of social desirability may be relevant to consider in this research for two reasons. Firstly, individuals may try to align themselves with the perceived views of the researcher, that is, they might have thought that I believed burnout was present and therefore only share negative experiences. Secondly, to be viewed in a positive way they may not wish to share their experiences as this might be perceived as a weakness.

Use of existing concepts

Another possible limitation is that pre-existing concepts were used in the interview schedule and recruitment flyer. These may have resulted in constraints on the discussions in the interviews. However, it is helpful to note that novel understandings and themes did emerge in the interviews and through data analysis which suggests the impact of this limitation was minimal and mediated within this research.

Reflections on implications for practice

As a counselling psychologist in training, I was mindful of my own ethos and professional guidelines when considering the implications. Therefore, these have been reflected upon with colleagues and supervisors. My reflections have made me more aware of my own therapeutic allegiances. I view myself as an integrative therapist who mainly worked within a Cognitive Behavioural remit within an IAPT service. I considered my own perceptions and assumptions and how this might impact on the hermeneutic, interpretations and implications of the research. At various times I reconnected with the initial audio or written

transcripts to ground myself and the analysis of the views that were shared with me by the participants.

Relevance to the Profession

As a counselling psychologist in training, it is important that I help shape the environments we work in. As a therapist working in IAPT and other mental health services I hope that this research can help open discussions in services, among individual therapists and on strategic and commissioning boards to help contribute to positive practice, wellbeing and effective therapeutic outcomes.

From a professional development perspective, understanding the relationship between burnout and therapeutic work is invaluable. As a practitioner, I will be more mindful of my own wellbeing and continue to practice self-care and reflection. Within leadership positions that may arise in my career I aim to bring a focus on wellbeing.

This research would have contributed to the knowledge in this area and offered qualitative findings which have been minimal in the small amount of research into IAPT that has been conducted to date. I hope that it leads to further research into wellbeing and resilience development and explorations of training, supervision and reflective practices.

As a qualitative study, using IPA it explored the experiences of the participants and contributes to our understanding of their experiences, which was the focus of the research question. This is relevant to the field of counselling psychology, which values personal and subjective experiences (Douglas, Woolfe, Strawbridge, Kasket & Galbraith, 2016). Using IPA opens up the subjective experiences of the therapists and keeps in mind the values of counselling psychology which focuses on '*meaning, beliefs, contexts and process*' (British Psychological Society, 2013, p.15).

Concluding Reflections

The journey of this research has been immensely meaningful, and I feel passionate about employee and community wellbeing in mental health organisations. The knowledge I have gained will impact on my identity as a therapist, supervisee, supervisor, and researcher. I feel my practice has been affected positively as I value the importance of current research, seeking a practice that is evidence based. I have learnt about burnout, stress, supervision, training and relevant interventions. This research has widened by knowledge based and contributed to my development as a counselling psychologist trainee.

Conclusion

The study aimed to explore the phenomenological and idiosyncratic experiences of burnout in IAPT services. The research revealed three main areas that were linked to the research questions; therapist wellbeing, caseload challenges and organisational support, each with subthemes. The findings provide deeper insights which can be related to existing research on burnout, stress, and IAPT.

Therapist wellbeing reflected on the emotional, mental and physical health of the therapist. Participants used words such as stress and burnout to describe their experiences. Burnout was viewed as a process which individuals tried to manage by using personal tools and changes to their roles. Turnover and illness in the teams reflected challenges to wellbeing for individuals and the sense of organisational wellness. Personal Accomplishment showed a cyclical relationship between stress and burnout.

The challenges experienced within the therapist's caseloads were the high number of clients they were expected to see and the complexity of the client presentations. Participants disclosed feeling they needed to have more time with the client to have a positive outcome and that they did not have enough time to prepare or reflect on work with clients. The therapeutic relationship was impacted by these factors, while the participants perceived they had good relationships within the therapeutic room, two of the participants shared their frequent hopes that the next client would not turn up and a shame that this carried with it.

Organisational support reflected on one of the larger implications for clinical practice that I hope could be an outcome of this study. Due to the complexity, and caseload numbers more supervision time may be beneficial. Brief supervision (caseload management) appeared to be at the forefront, in IAPT and while this is beneficial, more in-depth supervision that is reflective, and restorative is needed. In the discussion section, supervision models such as

Hawkins and Shohet (2006) and Proctor (1987) were argued to be of value as possible preventative factors mediating the participants' experience of burnout.

The dearth of time for reflection within these target-focused environments was raised by all participants who noted reflection as an integral part of their work which was often taken home into their personal lives. Many discussed a culture of endurance within the teams, Brad referred to it fittingly as '*sink or swim*' (289).

Training was viewed as a benefit and a challenge, while additional training made it easier for the participants interviewed to do their roles well. However often sufficient time was not allocated for the different tasks they had to complete as part of the training. One participant also found some training to be a trigger for an experience of burnout with associated mental health difficulties.

In conclusion, this study has addressed the research questions, reflecting on experiences of these ten participants working in IAPT. It is hoped this research would have provided a more comprehensive understanding of what it is like to work as a therapist in an IAPT service and therefore is relevant to counselling psychologists who regularly work as therapists or manage such teams. As counselling psychologists who value the therapeutic relationship, our efforts to ensure conscientious and ethical practice; sufficient training, supervision, and reflection will lead to better practice for the therapist, client, and change within organisations. While the improvements regarding accessibility of therapy in the United Kingdom cannot go unstated and un-praised, this study can help to ensure sustainably, reduced turnover and best practice for individuals who work within the IAPT framework.

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List of Appendices

Appendix A: UWE ethics approval

University of the West of England
BRISTOL

Faculty of Health & Applied Sciences
Glenside Campus
Blackberry Hill
Stapleton
Bristol BS16 1DD

Tel: 0117 328 1170

UWE REC REF No: HAS/15/07/188

24th July 2015

Crystyn Scott
[redacted]

Dear Crystyn

Application title: An Exploration of Burnout in IAPT services using Interpretative Phenomenological Analysis

Your ethics application was considered by the Faculty Research Ethics Committee and, based on the information provided, has been given ethical approval to proceed.

You must notify the committee in advance if you wish to make any significant amendments to the original application using the amendment form at http://www1.uwe.ac.uk/hls/research/researchethicsandgovernance.aspx

Please note that any information sheets and consent forms should have the UWE logo. Further guidance is available on the web: http://www1.uwe.ac.uk/aboutus/departmentsandservices/professionalservices/marketingandcommunications/resources.aspx

The following standard conditions also apply to all research given ethical approval by a UWE Research Ethics Committee:

1. You must notify the relevant UWE Research Ethics Committee in advance if you wish to make significant amendments to the original application: these include any changes to the study protocol which have an ethical dimension. Please note that any changes

approved by an external research ethics committee must also be communicated to the relevant UWE committee.

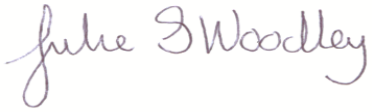
2. You must notify the University Research Ethics Committee if you terminate your research before completion;

3. You must notify the University Research Ethics Committee if there are any serious events or developments in the research that have an ethical dimension.

Please note: The UREC is required to monitor and audit the ethical conduct of research involving human participants, data and tissue conducted by academic staff, students and researchers. Your project may be selected for audit from the research projects submitted to and approved by the UREC and its committees.

We wish you well with your research.

Yours sincerely



Dr Julie Woodley
Chair
Faculty Research Ethics Committee

c.c *Rik Cheston*

Appendix B: NHS Research and Design Approval

Mental Health Partnership NHS Trust

Our Reference: 909

[redacted]
Research and Development

Crystyn Scott

A Mental Health Partnership NHS Trust

[redacted]

Date: 19th November 2015

[redacted]

Dear Crystyn,

Title of study:	**An Exploration of Burnout in IAPT services : An IPA study**
Approval date:	**19 November 2015**
End date:	**30 November 2016**

Thank you very much for applying to undertake your research in AWP, we pride ourselves on a straight forward and rapid process for research governance and project management.

As you are recruiting staff to participate in this research, the study falls outside the scope which requires review by the National Research Ethics Service, and therefore does not require an NHS Ethical Opinion.

R&D acknowledge the study will be asking staff to take part. Please take this letter as confirmation we are willing for staff to participate Trust-wide.

We now use EDGE (a Clinical Management System) to manage our research studies. As part of your approval you will be issued with an account and guide and will be expected to upload recruitment figures regularly. This is a requirement for all research recruiting in the Trust, including staff studies. Failure to comply with this will result in your research being suspended, so please make sure you complete this on a monthly basis.

The R&D Permission in the Trust is valid until **30 November 2016**. If you require any extension to this in the future please contact us to arrange

As you are conducting research within the NHS, you must ensure you abide by the research and information governance requirements:

- Work must be carried out in line with the Research Governance Framework which details the responsibilities of everyone involved in research.
- You must comply with the Data Protection Act 1998 and where required, have up to date Data Protection Registration with the Information Commissioners Office. Where staff are employed, this includes having robust contracts of employment in place and ensuring that staff are made aware of their obligations through training and similar initiatives.
- You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice:
-

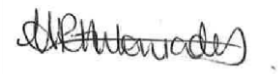
(http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicanddGuidance/DH_4069253)

Continued…

- You must have appropriate policies and procedures in place covering the security, storage, transfer and disposal of information both personal and sensitive, or corporate sensitive information. Any information security breach must be reported immediately to the Trust.
- Where access is granted to sensitive corporate information, this must not be further disclosed without the explicit consent of the Trust unless there is an override required by law. Where disclosure is required under the Freedom of Information Act 2000, the Trust will assist you in processing the request.

We hope you are successful in your study aims and objectives. Please make sure you let us know at the end of your study how it went by providing us with a copy of your final report. This way we can ensure those involved within the Trust are aware of your findings and can consider your recommendations. Please send a copy of your final report to [redacted]

Yours sincerely



Hannah Antoniades
Research & Development Operations Manager
A Mental Health Partnership NHS Trust

CC: Rik Cheston, UWE Project Supervisor & Clinical Supervisor

Appendix C: Interview Schedule

Thank you for coming today, I would like to remind you of the goals of the interview.

1. To understand your experience of burnout in IAPT (Improving access to Psychological Therapies).
2. Determine whether or not burnout affects your therapeutic work.
3. To understand your experience of emotional exhaustion (EE), depersonalization (DP) and personal achievement (PA) and how these relate to each other.

I would like us to start by you telling me a little about your work as a therapist in IAPT:

Burnout

Can you share with me your understanding of burnout?

Following this I would explain some research defines burnout as '*a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who 'do people work'* (Maslach and Jackson,1993,p 20).-Do you have any thoughts about this definition of burnout?

- If it does not emerge naturally in the interview I will introduce these prompts where relevant:
- Can you describe your feelings about your work?
- Tell me about your experience of burnout in your service?
  If participants say they have experienced burnout, I will ask the two questions below:

- What does burnout feel like for you?
- Can you tell me about a time or situation related to your work in which you felt burnt out?

Therapeutic Work

I may use the following prompts:

- Can you tell me how you feel burnout has impacted on how you view your patients?
- How easy is it to see your patients as individuals and be patient centred?
- Tell me how you feel burnout has impacted the therapeutic relationships with you patients.
- Can you tell me how burnout may have affected your therapeutic work overall?

Emotional exhaustion, Depersonalization and personal accomplishment

I may use the following prompts:

- Thinking about the definitions given for burnout and emotional exhaustion tell me about your experience of emotional exhaustion?
- Can you tell me how your empathy has been impacted since starting working in this field? (DP)
- When you think about your work can you give me a sense of how it makes you feel regarding your personal accomplishments?

Other possible prompts:

- Tell me about your caseload presently.
- How has this caseload impacted on you?
- Tell me how you been affected when your caseload was high?
- Tell me some of the issues that these clients are bringing into sessions? /Describe your work?
- What would you say is the most challenging part of your work?

Concluding interview:

- Anything else you would like to add? Any aspects that you think I have not covered? Is there anything that you would like to ask me?
- Would you have asked anything differently? (Pilot interviewees only)

Appendix D: Participant Information sheet

Faculty of Health and Applied Sciences

University of the West of England
BRISTOL

PARTICIPANT INFORMATION SHEET-Version 3 Dated 06.07.2015

Study title

An Exploration of Burnout in IAPT services: An insight into causes and effects.

Intervention and Brief Summary

This research will be investigating burnout in the Improving Access to Psychological Therapies (IAPT) services in the United Kingdom. I will be conducting interviews to gain insight into therapist experience of burnout and the challenges affecting them.

Explanation: purpose of and background to the research

The research is explorative in nature; it will help to improve our understanding of the experience of therapist burnout in IAPT services. I have chosen to explore this as I currently work in IAPT as a therapist and am aware of some challenges facing workers; I think this research can provide valuable information about challenges and experiences of therapists within services.

The research will consist of a semi-structured interview.

Approximately sixteen (16) Participants will be involved in the interviews. All participants will be Step two/ Psychological Wellbeing Practitioners and Step Three/Cognitive Behavioural therapists and Counsellors. Interviews will be held in a location that is convenient for participants and alternatively telephone interviews can be offered.

Inclusion Criteria

- Presently working an IAPT service or have worked in such a service in the last year.

What would taking part involve?

Participating in the interviews will involve meeting with me (Crystyn Scott) for a semi-structured interview in person or via skype and would take up to sixty (60) minutes. All interviews will be recorded and transcribed later.

What are the possible benefits of taking part?

As IAPT is a relatively new service it would be beneficial to have research that offers perspective of the therapist themselves, it will help commissioners and managers to be aware of what is working well and what can be improved. As IAPT continues to change research can provide the opportunity for informed decision making. It would also allow participants to give insight the own experiences.

What are the possible disadvantages and risks of taking part?

There is a low risk of psychological distress for therapist involved and should this arise the therapist can withdraw from the study and be directed to psychological services or whatever is most helpful at the time.

What if I am negatively impacted by participating?

While it is unlikely that participants would be negatively impacted by the study, if you experience any distress directly related to involvement in this study please contact us using the details given below.

Who is carrying out this research?

This study is being conducted by Crystyn Scott, a Trainee Counselling Psychologist at the University of the West of England (UWE) in partial completion of the doctoral programme. My research is being supervised by two HCPC registered psychologists. This study has been reviewed by the Postgraduate and Ethics Committee at UWE.

How do I withdraw from the study?

If you need to withdraw from the study at anytime or have any questions throughout please contact me at [redacted], alternatively you can contact my supervisor Professor Richard Cheston on [redacted]. Following the interview participants can withdraw the information given up to two weeks after. Participants are reminded taking part is entirely voluntary.If participants decide to withdraw after they have finished the interview, you will have the option of asking me to destroy the recording and any transcript.

How will the information gathered be used?

The results of this study will be submitted for viva at the end of the doctorate and publication. Confidentially is paramount, all data will be encrypted and stored in a locked filing cabinet and help in accordance with UWE and NHS data protection protocol and participant details will not be shared and the study is solely funded by the researcher. At the end of submission all recordings and transcripts will be destroyed. Thank you for your consideration and participation in this research.

Two copies of the consent form Version 3 Dated 06.07.2015 have been provided and one copy will be kept by the participant.

Contact details for Crystyn Scott (work address)

[redacted]

Appendix E: Consent Sheet

Faculty of Health and Applied Sciences

University of the West of England
BRISTOL

CONSENT FORM

PARTICIPANT CONSENT FORM Version 3 Dated 06.07.2015

Title: An Exploration of Burnout in IAPT services: An Interpretative Phenomenological Analysis study.
Name of Researcher: Crystyn Scott

Please initial box

1. I confirm that I have read the information sheet (Version 3) dated..... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason prior to the interview being conducted. Following the interview I am aware that I can withdraw the data provided up to two weeks after interview. ☐

3. I understand that any information held about me will be stored in encrypted files to maintain privacy and confidentiality; I understand the researcher will make every effort to publish data anonymously. ☐

4. I am aware that all data from the study will be destroyed following submission and publication. ☐

5. I agree for my data to be stored anonymously and that any published quotations or extracts from the research will maintain my confidentiality. ☐

☐

6. I agree to take part in the above study.

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Two copies of the consent form Version 3 have been provided and one copy will be kept by the participant.

Contact details for Crystyn Scott work address:

[redacted]

Appendix F: A Sample of Analysis

Line	Transcript	Coding Descriptive, Linguistic, Conceptual	Themes	Supervisory Teams' comments
	(Interviewer does introduction and protocol)			
1.	**Respondent:** Ok so I've be working	"OK" eager to start. Sounds proud of how		
2.	for the service that I'm working for	long he has been there. He has different	Training in IAPT.	
3.	now for the last four years. Umm..	roles in his background. Pride in his		
4.	Started as an assistant psychologist	masters. "Therapeutically" distinction		
5.	whilst I was doing a Masters in Neuro	that he has had other experiences.		
6.	Psychologies. My, therapeutically my	"Wolly", sense there is a straight forward		
7.	background kind of was a little bit	route (into IAPT). Perhaps measured		
8.	woolly to say the least, so as an	against benchmark. He moved from being		
9.	assistant psychologist I was trained in	an AP to providing LICBT, essentially		
10.	low intensity CBT therapy so I was	transitioning into an IAPT role. Use of the		
11.	working with anxiety, depression. As	word progress suggests he saw this		
12.	I, as I kind of progress through the	change as improvement. The role lead to		
13.	service umm and I started to pick up	more opportunities, he is now lead on a		
14.	different roles and different projects	specialty.		
15.	and things. I currently lead, I'm the			
16.	current service lead for autism	Use of 'Yeah…kind of my role' suggest		
17.	spectrum conditions in the service and	identification with that part of the job but		
18.	learning disabilities as well. Yeah so	not full satisfaction. This possible lack of		
19.	that's, that's kind of my role. At the	satisfaction is evident when he quickly		
20.	moment I'm training to be a high	moves to training he is currently doing,		
21.	intensity CBT therapist so my time is	tone suggest perhaps he is more pleased		
22.	split between the University and	with that?	Struggling with	
23.	studies and kind of practising that	His time being split between studies and	time.	
24.	during sessions.	work. He is 'kind of practising' A sense of		
25.	**Interviewer:** yeah and how has that	uncertainty and lack of space and time.		
26.	changed your role over the time that	further training. (Positive) opportunity.		
27.				**Supervisor 2**:

28.	you've been kind of there. How's your		Pride in his work.	Changes in role /
29.	role changed there	Change in his role might have impacted	Personal	responsibilities
30.	**Respondent:** So it's changed in quite	on his responsibilities and time off	accomplishment	may be a central
31.	a few ways, I've found that over time	sick/burnout. Skills mean more work. Use		factor in burnout
32.	as, as I've become more skilled, as I've	of word responsibility suggest weight on		and there is
33.	skilled up my experience levels have	him. Skills translate into more	High caseload.	potential for
34.	improved. I've found, I tend to pick up	people/patients, caseload can lead to		elaborating on this
35.	a lot more responsibility and as	burnout.		
36.	people, and I'm currently I'm now			
37.	working as psychology practitioner but	Notes progress from when he first joined		
38.	obviously, so I'm working in GP	the team.		
39.	surgeries and things like which was a			
40.	step up from where I previously was	Change in role has led to management of	Responsibility	
41.	when I first came in. More so I've sort	others. Again, he uses the word		
42.	of managed the group of assistant	responsibility, adding the word 'duties'		
43.	psychologists under me as well so	but stated it was gradual, the way he	Struggle with time	
44.	incrementally picked up a lot more	phrases it, as if it snuck up on him over		
45.	(pause) responsibilities and duties as	time. He comes back to the idea of having		
46.	time has gone on but the more you do	less time and more to do. Repetition is an		
47.	the less time you have to do it	interesting linguistic insight. I have a		
48.	**Interviewer:** so you feel like you have	sense he is conflicted by wanting to		
49.	a lot more responsibility now and a bit	progress but also noticing all the		
50.	of less time	responsibility vs time issue.		
51.	**Respondent:** yeah absolutely yeah			
52.	**Interviewer:** so thanks for sharing	Confirms understanding, seems to be		
53.	that with me. I think the next thing	reflecting himself.		
54.	we'd like to do is umm look at your			
55.	understanding of burnout. Can you			
56.	share with me your understanding of			
57.	burnout?			
58.	**Respondent:** yeah so I suppose	Reflects his understanding of burnout.		
59.	burnout is just, yeah it's a modern	Overload being a key concept. Stress that	Stress	
60.	name for stress really isn't it? It's	impacts on functioning.		

61.	overload, it's feeling that you can no		More	
62.	longer function. I think	He notes that burnout for therapist is	responsibility, less	
63.	therapeutically burnout is quite	different. Discusses skills development as	time.	
64.	interesting because it's slightly	leading to more responsibilities and		
65.	different from what you would expect,	duties.		
66.	umm because of the nature of our	Appraisals of having less time with more		
67.	roles, which is a lot of containing and	work. The nature of the role of therapist		
68.	a lot of holding of quite a high to a	makes this burnout different		
69.	high degree I a high degree of	conceptually. 'Containing' and 'holding'		
70.	emotionally distress, you work with	further highlight elements of	Reduced coping.	
71.	emotionally distress every day, umm	responsibility.		Supervisor 1:
72.	when it gets to a point where you can			Is there some
73.	no longer contain, you can no longer	Uses distancing language, 'you' perhaps it		distancing
74.	function effectively as a therapist or as	is to difficult for him to refer to himself in	Emotional	language here?
75.	a line manager or a line managee,	the first person, he starts saying I then	exhaustion	"you work with …
76.	when you're struggling you know to	switches. Further distances by saying 'it.		you can no longer
77.	get up and the motivation goes and	His ability to function his negatively		contain.."?
78.	anxiety creeps in and frustration and	affected. Burnout affects him wanting to		
79.	anger creep in, that's kind of burnout,	get up and anxiety, frustration and anger		Supervisor 1:
80.	that absolutely loss of capacity to	come into play. Individual loses the		
81.	cope really	capacity to cope.		EE is the construct -
82.	**Interviewer:** Ok so you're kind of			perhaps your
83.	seeing it as something very different			emerging themes
84.	in the therapeutic world than it is in			should relate to
85.	the regular world for you			what participants
86.	**Respondent:** yeah absolutely yeah. I			bring, not to what
87.	think it's, I think there's something			you impose on
88.	unique about umm I mean obviously,	Unique might refer to IAPT, and therapist		that?
89.	people get burnout in different jobs	in general. Clear distinction that this is a		
90.	and different roles and I see a lot of	specific kind of burnout. He implies a		
91.	people who do get burnout you know,	level of intensity that is evident in role.		
92.	see people who work umm in the			
93.	criminal justice system or people who			

94.	work in sort of for banks or whatever	There is an emotional part of burnout that is characteristic of this for therapist. The contrast he makes to 'bankers' highlights the meaning of this difference for him. A banker can be associated with methodical tasks but, the tasks of a therapists are reliant on emotions. Perhaps the word bank is a stubble, psychodynamic reference of a contained limited resource, that is psychological therapist's emotions.		
95.	it is you know but I can really identify			
96.	that there are certain distinctions			
97.	between burnout for a banker and			
98.	burnout for a psychological therapist.			
99.	It tends to be more of an emotional			
100.	component, psychological therapists.			
101.	**Interviewer:** ok so very clear that it is			
102.	the emotions that are driving that			
103.	sense of condition			
104.	**Respondent:** absolutely yeah			
105.	absolutely.			
106.	**Interviewer:** so I'd just like to share			
107.	with you a definition of burnout that			
108.	we're using in this research and it			
109.	defines burnout as 'syndrome of			
110.	emotional exhaustion,			
111.	depersonalisation and reduced			
112.	personal accomplishment that can			
113.	occur among individuals who do			
114.	people work' and that's from Maslach			
115.	& Jackson 1993. So looking at that I'll			
116.	share that with you there, so looking			
117.	at that do you think umm what do you			
118.	think about that definition, any			
119.	thoughts			
120.	**Respondent:** umm yeah its a good			
121.	thing, so a syndrome of emotional	Appears to be processing the definition. Stressed the Use of the word 'broad' seems to have a negative tinge but he says he agrees with this. Agrees that burnout is a varied experience.		
122.	exhaustion, depersonalisation and			
123.	reduced personal yeah that seems to			
124.	fit umm so broadly speaking it's a nice,			
125.	*broad* generalised view of what			
126.	burnout could be I would certainly			

127.	agree with that, yeah that framework			
128.	yep			Supervisor 2: Engaging with a new thought, lack of personal accomplishment has specific meaning for this participant
129.	**Interviewer:** does anything jump out			
130.	to you there in terms of any words			
131.	different from what you understood			
132.	**Respondent:** the lack of personal	Considering, he is doing training presently it is curious that his is the first thing that he speaks about here. He appears to be engaging in a new thought suggesting lack of personal accomplishment has a specific meaning for him. PA for him comes back to the clients, burnout makes him achieve less, the process escalates as he before more frustrated, impacting on clients. This process comes back to the clients again in the form of weaker interventions and less success.		
133.	accomplishment, I hadn't thought			
134.	about that component before, I think			
135.	that's quite interesting I think that's			
136.	actually quite helpful umm because			
137.	you do achieve less and then that			Supervisor 1: Again, this seems your word. Can you provide evidence of how the hermeneutic process is working here? (CS Removed based on discussion)
138.	becomes frustrating, you know it's			
139.	certainly again therapeutically you are			
140.	achieving less with the clients, you're		Negative impact on the therapeutic relationship.	
141.	being less successful with			
142.	interventions because your mind's not			
143.	really focussed on it and so the			
144.	implications for that then are more			
145.	pressure, more stress because you're		Decreased therapeutic effectiveness.	
146.	starting to develop these unsuccessful	Pressure brings a visual image, stress on one side and perhaps needing to do the work on the other. The unsuccessful is a valuation of the impact of the quality of the relationship. I wonder if this is correct? The quality of the work, with the interventions and the relationship begins to deteriorate with burnout. His use of the word 'drive' and speed of speech suggest he is slowly gaining this insight.		
147.	therapeutic relationships which then			
148.	drive that sense of burnout and drive			Supervisor 1: Starting to explore relationship between quality of work and burnout
149.	that sense of that's quite an			
150.	interesting insight			
151.	**Interviewer:** so I'm just kind of			
152.	wondering about when we think			
153.	about burnout umm if you could tell			
154.	me a bit about your feelings about			
155.	your work at the moment			
156.	**Respondent:** so at the moment I feel			
157.	quite positive about my work, umm it			
158.	is difficult, training's always difficult			
159.	because you are trying to apply umm			

160.	new skills and techniques to an	He views things positively clear in		Supervisor 1:
161.	existing therapeutic framework which	repeating and specifying that this is at the		
162.	is, or a therapeutic approach or style	moment. This might mean there is an		There seems an
163.	which you've sort of developed over	awareness that this changes. He says on		element of pride
164.	time so there is a little bit of stretch	the training he is doing he and his		here again, you
165.	going on so you know different	colleagues have more work than other	Pride	commented in
166.	dynamics you're interplaying but I feel	people on his course. From his	Being a Survivor	something similar
167.	broadly positive in some respects. My	perspective, the demands and	Organisational	above?
168.	workload is very high umm and	expectations exceed his resources. I	support	
169.	compared to the rest of the cohort on	notice his need to compare himself to		Supervisor 2:
170.	my in my year group, I don't think	others comes up several times (162). The		Yes I agree and this
171.	there are many, with the exception of	experience of being on the course with		is a good example
172.	the other people in the same service	these challenges, gives him a sense of		of where you can
173.	as me there are very few people who	pride. This pride might come from		achieve greater
174.	actually are still doing X amount of	knowing its difficult but facing the		depth of analysis in
175.	step 3 clinics plus HI CBT, plus all of	experience relating to his view of being a		identifying what is
176.	the additional responsibilities I was	Survivor. 'Still doing x ...clinics' suggests		underlying the
177.	already holding	that even if training is offered its at one's		participant's words
178.	**Interviewer:** yeah	own expense, they must keep up with		
179.	**Respondent:** so that's quite a push	existing roles. Discusses differences in the		
180.	**Interviewer:** do you feel like the	support offered by organisations who are		
181.	people on the course that you're	sending individuals to training. 'Push'-he		
182.	doing they have it a bit easier when	is working at it, the experience isn't easy		
183.	they work from other services	to hold.	Caseload impact.	
184.	**Respondent:** some and some, I think		Organisational	
185.	it all depends, I think you know it's a		Behaviour.	
186.	tough one to judge because you know	Acknowledges that other colleagues from		
187.	those people may well have lower	other services are also find it hard for		
188.	works, caseloads but they're also not	because of other organisational		Supervisor 1:
189.	getting paid the same amount of	pressures. Frustration and resentment		This seems to be
190.	money or they may not be supported	toward the organisation due to lack of		coming out a few
191.	in other ways so some people aren't	support feed into the negative		times - his contrast
192.	getting paid for expenses things like			

193.	that so it is a trade-off and those	experience. Refers to the caseloads being a mediating factor.		with peers - worth commenting on?
194.	things equally can cause frustration			
195.	and resentment in a different	He contrasts himself to peers and other services, this might play a part in how he makes sense of his experience. This comparison schema can fit into his survivor narrative. He has to work harder and do more than others to survive the training. 'intense' to describe service, implies negative judgement, comparison and complexity.		
196.	approach but I think from my own			
197.	perspective yeah there is a real sense			
198.	that I am, demands on me at the			
199.	moment far exceed with the			
200.	exception of my peer, you know peers			Supervisor 1:
201.	colleagues who I work with within my			Ditto his contrast
202.	own service seems to be a lot more			between his own
203.	intense than other services,			service and others
204.	absolutely.			
205.	**Interviewer:** ok so you, kind of feel		Strain/Sense of overload	
206.	that there is some trade-offs as you			
207.	said, differences between services and		Barely coping(209,	
208.	you're feeling a bit stressed, stretched	(Summarising)	210,203)	Supervisor 1:
209.	sorry to be correct out of all that			You refer below to
210.	**Respondent:** yeah absolutely feeling			overload - this also
211.	really stretched, umm yeah definitely			seems to be an
212.	**Interviewer:** so can you tell me about	'stretched' furthers the imagery of strain and struggle. Difficulty survival		example of that?
213.	your experience of burnout in your			And I think here
214.	service			again is a
215.	**Respondent:** so I think previously I			description loaded
216.	have got to the point where, in my	In his experience of burnout he feels overwhelmed, image of strain and pressure conveyed.		with emotion so
217.	prior experience where I have just felt			needs to be
218.	overwhelmed			commented on
219.	**Interviewer:** your prior experience			
220.	**Respondent:** so sorry just in recent	(Clarifying)		
221.	you know in recent times and I say	The experience he has shifts and changes, currently having a sense of overload. Struggling to balance the training and caseload.	Overload/Stress/Strain	
222.	prior experience because its, whilst its			
223.	ongoing there are some, there have			
224.	been some subtle shifts that allow us			
225.	a little bit more space, however I			

226.	suppose my experience really is just		High Demand and strain. No opportunity for reflection.	
227.	that sense of overload so you know			
228.	I'm doing quite a few clinics and so			
229.	each clinic will involve seeing people			
230.	back to back, four people back to back	seeing clients back to back, quickly writing notes before the other person comes in. States there is no space for reflection or considering client's problems. 'Important therapeutic reflections' and integral part of his job isn't getting the space it needs.		
231.	for 50 minutes a pop. There's no			
232.	space in between, you get 10 minutes			
233.	to write your notes and then you are			
234.	back on it straight away so there's no			
235.	space to reflect, to consider the			
236.	problems that that client brought, you			
237.	know those important therapeutic			
238.	reflections and there's no opportunity			
239.	to do that or there's less opportunity			Supervisor 1: Repetition of a word always interesting
240.	to do that if you're seeing a block of	Describes holding and experiencing emotions in the room. The experience is emotionally draining-heavy experience of understanding the client and dealing with their emotions. He then needs space to process that but cannot. Repeats the word 'Really, Really' invokes the level and depth of impact on him and the concept is meaning to him. He really needs this space to reflect(245,246). Without this space to reflect his resources are drained, depleting but his tools are in use all day so those two things don't fit.	Emotional work requiring emotional energy.	
241.	four then you have an hour for lunch			
242.	followed by another block of four so			
243.	that's <u>really, really</u> draining in terms of			
244.	the experience, from an emotional			
245.	perspective formulating, working with			
246.	those people, going through those			
247.	experiences with them kind of really			
248.	experiencing that in the room, then			
249.	they leave and you know the			
250.	opportunity then to I suppose to			
251.	offload and to you know is limited in			
252.	that sense because you've just got to			Supervisor 1 : Again, repetition of really - shows that this concept is ++ meaningful to him/her
253.	pick up and get on with it and so over			
254.	time that can become <u>really</u>			
255.	<u>demanding and really draining and</u>			
256.	<u>really</u> quite hard work			
257.				
258.				Supervisor 2:

259.	**Interviewer:** how is it for you going			Also powerful
260.	from one patient to the other, four			words reflecting
261.	back to back? What is that like for you	'Test' interesting choice of words that	Emotional energy	strength of feeling
262.	**Respondent:** it's difficult it's, umm it's	might play into the survivor narrative.	Impact of material	Supervisor 1:
263.	a real test of, it's a test of a number of	Empathy is viewed as a limited resource		Again, distancing
264.	things it's kind of the empathy there	that is difficult to replenish when moving	Difficult material	language in the use
265.	that empathic input you know you're	quickly between patients. Again, the use	and clients are not	of "you"??
266.	kind of switching from one person's	of contrasts referring to clients and the	the 'mild to	Supervisor:
267.	life story to a different life story so	materials they bring. It's difficult to offer	moderate'	Passive tense being
268.	you can be going from you know some	the same level of empathy when	expectation within	used here. So not
269.	the worried well's with mild anxiety	switching between someone who has	IAPT services.	saying "I need to
270.	about something to somebody who's	been abused and someone with a less		have a huge
271.	had childhood sexual abuse to	intense story. Mindfulness of each client's		amount of energy"
272.	someone who's just experienced a	distress seems to shift. Appraises		but "that requires a
273.	really horrific loss or bereavement of	challenges to the materials he deals with		huge amount of
274.	some sort and actually that requires a	in sessions and the emotional energy.		energy". Perhaps a
275.	huge amounts of emotional energy			distancing
276.	and also a huge amount of creativity	Clients bring difficult material such as		technique?
277.	as well and mindful to guide the	sexual abuse, horrific bereavements		
278.	session in a way that is benefitting the	which need creativity.		Supervisor 1:
279.	client and you know to kind of giving	His use of passive tense, can be a		"Either …. Or …"
280.	you the optimum outcome and that	distancing technique, reflecting that it is		sentences - these
281.	can be difficult to maintain over a long	hard to face this experience.		are an important
282.	enough period of time and that	(They may not fit the regular IAPT model).		construction -
283.	becomes really difficult. I think it's a	'I think it's a sink or swim job' reflects	Challenging work	framing work in a
284.	sink or swim job, umm I think its	dichotomous way of thinking and	environment.	dichotomous way
285.	**Interviewer:** What do you mean by	conceptualizing the role.		
286.	that	Either or language suggestion of	Positive self	Supervisor 1:
287.	**Respondent:** so it's you can either run	dichotomous thinking. The metaphor	evaluation of being	
288.	with it and do it or you burnout and	suggests that the struggle is a rite of	able to stay in the	use of metaphor,
289.	you can't and it's a baptism of fire the	passage in the service.	environment.	albeit rather
290.	service I work for umm where they	intensity of the language – sick or swim /		clichéd, so
291.	basically throw you in at the deep end	baptism of fire captures the sense of	Internal attribution	something of a rite

292.	and you are, you sink or swim and	being pushed to the cliff edge – extreme descriptions or what he feels is an extreme experience. Describes his service as a *Baptism of Fire.* People seem to either struggle and swim or sink and leave. Extremity and intensity within a therapeutic environment. Appraised himself as being able to swim but puts this down to luck and some techniques, not organizational support. Dichotomous thinking. Use of 'you' distancing language even when asked directly about his own expectation. There is the framework of support, supervision is present but the quality is not adequate. Initially says supervision in present but explains there is not enough time and he is unable to take everyone so must make judgements and prioritize. The level of supervision recommended by many training courses and bodies is 1:8 hours so this number of clients combined with the ratio of supervision and a training course feeds into this negative experience. Rate of speech here is quick, sense of passion or high emotion.	Pride Organisational support Supervision Stressful supervision. Complexity of clients.	of passage??? Again, both dichotomous contrasts and use of commonplace metaphors. Supervisor 2: Again I'm struck with the intensity of the language – sick or swim / baptism of fire captures the sense of being pushed to the cliff edge – extreme descriptions Supervisor: He's doing a lot of discursive work here - squaring a circle of having support but not being supported. Supervisor 1: For myself, I find this appalling - my reaction is that s/he must know that this level of workload is not compatible with
293.	that's how it works. I've been lucky			
294.	enough to swim, I've found little			
295.	techniques that I can do, little things			
296.	that I incorporate into my day that			
297.	allow me a little bit more space but			
298.	that's self-management rather than			
299.	service support which are two very			
300.	different things			
301.	**Interviewer:** so that sounds a bit			
302.	difficult for a therapeutic environment			
303.	to be in a therapy environment that			
304.	that's very sink or swim, is that what			
305.	you felt you expected when you went			
306.	into this job area			
307.	**Respondent:** no, you were hoping.			
308.	See among my expectations were			
309.	always wanting to be you know to be			
310.	supported and there is support, we do			
311.	have supervision however the			
312.	supervision isn't adequate to a			
313.	degree. You have one hour to review,			
314.	I can see up to thirty clients a week			
315.	you know, maybe less sometimes you			
316.	know but I've less now I'm doing the			
317.	HI training but if I'm seeing twenty			
318.	clients a week an hour is not an			
319.	opportunity to really offer me. I could			
320.	spend 40 minutes talking about one			
321.	those and so there isn't really enough			
322.	space to be able to negotiate you			
323.	know the difficulties we encounter in			
324.	that sense so from a service			

325. **326.** **327.** **328.** **329.** **330.** **331.** **332.** **333.** **334.** **335.** **336.** **337.** **338.** **339.** **340.** **341.** **342.** **343.** **344.** **345.** **346.** **347.** **348.** **349.** **350.** **351.** **352.** **353.** **354.** **355.**	perspective whilst they attempt to be supportive it's not adequate by any stretch of the imagination **Interviewer:** does supervision really impact on your feelings of burnout as well **Respondent:** yeah absolutely. Umm supervision can be quite a stressful experience. Trying to decide of who of the half dozen or so high complex people that you've seen that week to bring to discuss, where do you start? And then you feel, well I feel umm that you're short changing the other people, you're not giving them the opportunity to you know to, they're losing out the benefit and the insight from my supervisor which is unfortunate so it's a tough balance and it's always a hard point to call umm so prioritising becomes difficult sometimes when everyone is a priority **Interviewer:** yeah, yeah **Respondent:** you know **Interviewer:** so you are kind of weighing up different people's stories and their different lives **Respondent:** yeah and then trying to have to make that judgement which feels unfortunate, it's an impossible position to be in	There is a sense of holding a number of clients and his training. 40 mins on one client suggest an alliteration of complexity. He is having to negotiate and hold the clients he is unable to take. He sees the service as wanting to give supervision but not meeting the needs of the workers. Supervisor: For me this is the person trying to look at squaring a circle of wanting to deliver a good service but not being given the chance to do so Challenging and appears to be left with some anxiety. He is trying to make sense of some circular logic of wanting to deliver a good service but not being given the opportunity to do so. Supervision can be stressful. The clients can be high in complexity but there are many of them. He appears to be holding the responsibility for these people not being taken when it is a service issues. It's difficult to see in the room the weight this has on him. 'Everyone is a priority' speaks to his own beliefs, this is not the way he would work if he had a choice. The service might have limitations but he is the one facing the people. Unfortunate is a minimizing word. He describes the essence of burnout which is being in an 'impossible position' deciding who gets prioritised.	Struggling to make sense of it (321-324)	giving each person the level of thought and care that they deserve. So I would be looking for some evidence that the participant knows this - they are trying to find a way to find a way of justifying themselves, that is to allow themselves not to feel guilty at this bonkers way of working. But then, that's my hermeneutic - how do you respond to what is being said?? Supervisor 1: What's your reaction to this acknowledgement of therapeutic limitations? This seems like an important statement

				Supervisor 1: This is important!!! Doesn't this relate to burnout??? Supervisor 2: Yes I agree, It captures it in a nutshell.

Appendix G: Example of Reflective Journal

Journal for Susie

Page 5-Discussion on the need for personal therapy resonated with me. I have had personal therapy as part of my doctorate training and did the CBT course with no therapy prescribed and felt it was essential.

Throughout pages 5-7 I find myself impressed with how much she takes an active role in her own wellness. She is aware she is fallible and human and works with that.

293-304 She discusses the difficulties of working fulltime. I try to stay focused on this interview in itself but I find myself thinking about the other interviews where comments were made about the difference between fulltime and part-time working.

341-344 When she speaks of 'frontline' I empathise with this. I think of the challenges of having the least trained (in the non- pejorative sense) assistant psychologists as opposed to Psychologist or someone with more training seeing quite complex people. It sounds like the drop-in service isn't been taken up by the intended audience. I think about literature which uses the same term 'frontline' to describe IAPT workers, it resonates with me.

I reflect on the imagery of war that comes to mind and wonder if that's my own stuff not hers.

411-419 There is indeed a GAP. It's well known but as all service are pressured the clients are seen in a way that might not be best for them. I understand an empathize with her experience. With a wider lense I'm also mindful that this way of working puts pressure on an already stretched service which means the gap is not addressed in a timely manner.

425-427 She explains clients maybe seen who have a care coordinator. I understand currently that secondary care might not have as many therapists as they need so clients might just be risk managed by them but they see an IAPT practitioner and I have mixed views on this. The clients

need to be seen but again there is more pressure. I feel worried for the weight that might carry for this therapist. She does not seem distressed by it currently which is positive.

476-496 Its interesting that she uses several coping strategies to assist her. This struck me as being really positive, but that the onus was largely on her to keep herself well in a challenging environment.

I felt it was important to include her coping themes as it could provided a more balances perspectives throughout the research.

There were still days she was talking it home. Its is impacting on her personal life. For themes such as impact on homelife and Supervision I am aware that there are both positive and negative implications for her and I will indeed reflect this in the write up.

Sickness 708-717 This really resonate with me. I completely understand where she is coming from. I used to feel like this and go in sick. I recall a client saying to me, next time stay home. I just felt like I came in to do good and now that was not being seen and If I stayed home how would people be sure I was ill. For me I think this comes from values I learnt from my mother. I wonder if this participant had any similar experiences that made her think this way. Perhaps she has a strong work either. I wonder if this comes from an internal or external source?

When she discusses others having more work because she is off I do not think this should be the case. Therapy is one of the environments where it's not a shared workload so people should not have to do more if others are sick. Their clients and drop in services should be cancelled unless there is someone with high risk.

This brought up high emotions for me and I hope she can really stick to these adapted beliefs.

760-767 When staff are off sick or leave the remaining staff have to pick up the work. This feels harsh. In a sense it's a system that is built around the idea that people are not sick or leave. I think about David Clark's presentation for BPS COP this year. He states that turnover in

PWP's s 20% and many suggest it is a lot higher. If this is at least 20% then it needs to be factored in, or essentially people can be punished for staying. I get the feeling its expected that staff will exhaust themselves and leave and this is something that was said in the first IAPT service I was involved with essentially get all the work out of people before they can't work in therapy anymore?

I feel sad and angry for her team. Because of my own feeling I am careful not to add too much of my own experiences in understanding her experience. I refer to Smith and Flowers who suggest that to stick as close to the wording as possible one might start at the end and read each sentence from the bottom of the transcript up to focus on the words themselves.

Overall this was a very interesting person to meet with. She was surviving in a difficult environment and very positive about her experience. It contributed to balance in the research. I struggled occasionally with dropping the other interviews I analysed but sat and reflected on this often. I re-read the interview again a few days after analysing, listening the recording and picturing the interview to reconnect myself.

I continue to write, draw and use free association to connect myself to her words and attempt to make my unconscious reactions conscious.

Appendix H: List of Clustered themes

Table showing a list of clustered themes

Work in surgery.	Therapist as a 'seller'.
Impact of waiting list.	High Caseload
Therapeutic options for clients.	Supervision Ratio
Emotional and psychological exhaustion	Seeing clients back to back
Burnout as a continuum.	Implications of overbooking.
Supervision-reflection	Positive individual coping strategies.
Active self-care.	Impact at home
Personal therapy and training.	Help seeking behaviours.
Personal therapy-resilience.	Re-grounding oneself.
Reflective space	Impact on home life.
Self-care	The need to refocus
Work and home life balance	Caseload
Sustaining	Differences between IAPT services
Personal life and coping.	Preventative Strategies
Personal therapy-resilience	Measurement of therapeutic effectiveness.
Managing responses to triggers-positively.	Complete Burnout
Difficulty working Fulltime.	Burnout as a continuum
Benefit and need for role diversity.	Illness
Unsustainability of fulltime work.	Fitness for work
High volume and the therapeutic relationship.	Reflection and Wellness

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[2] Ethical approval was gained from the University of the West of England. This approval was received July 2015, reference: HAS/15/07/188

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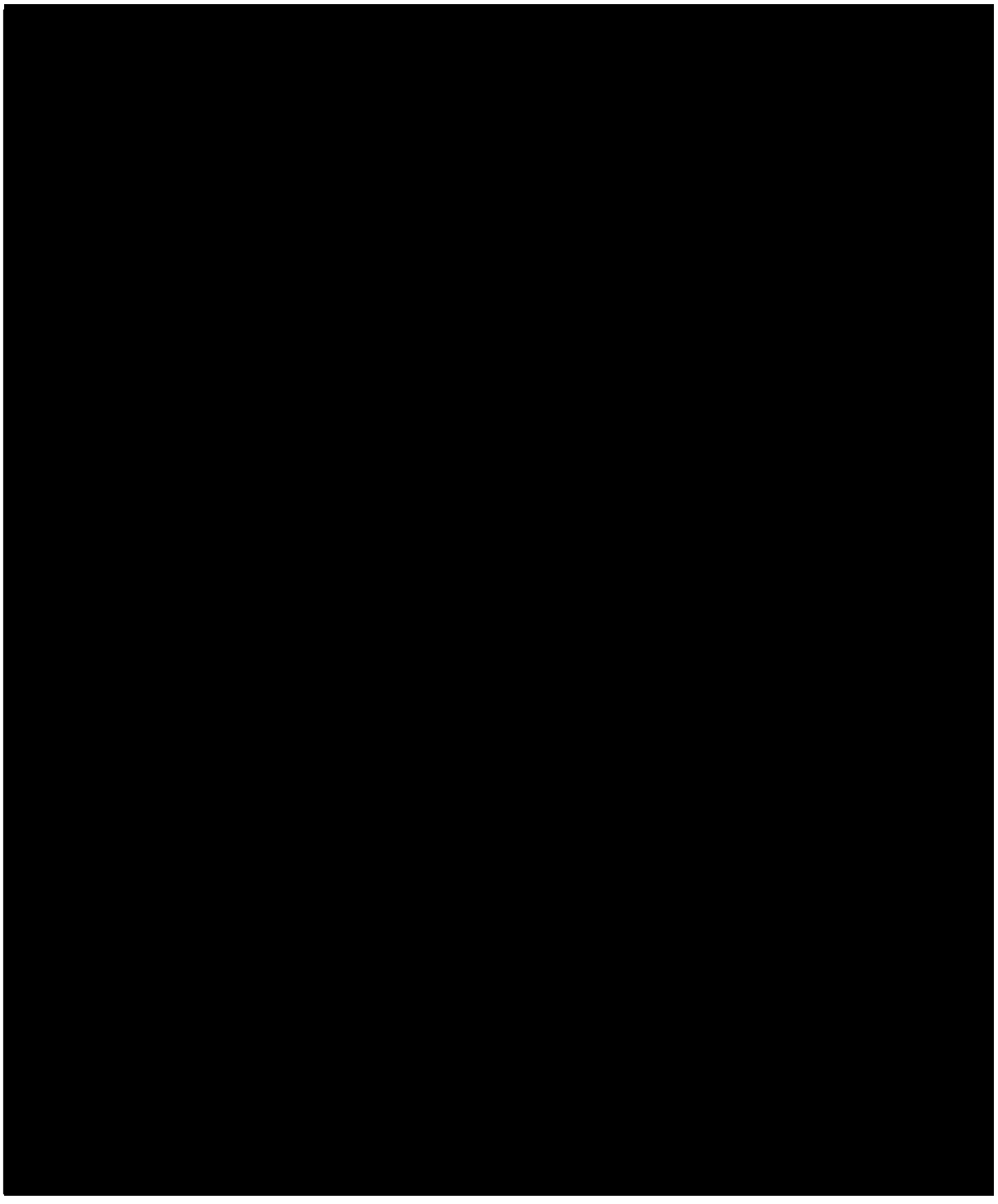

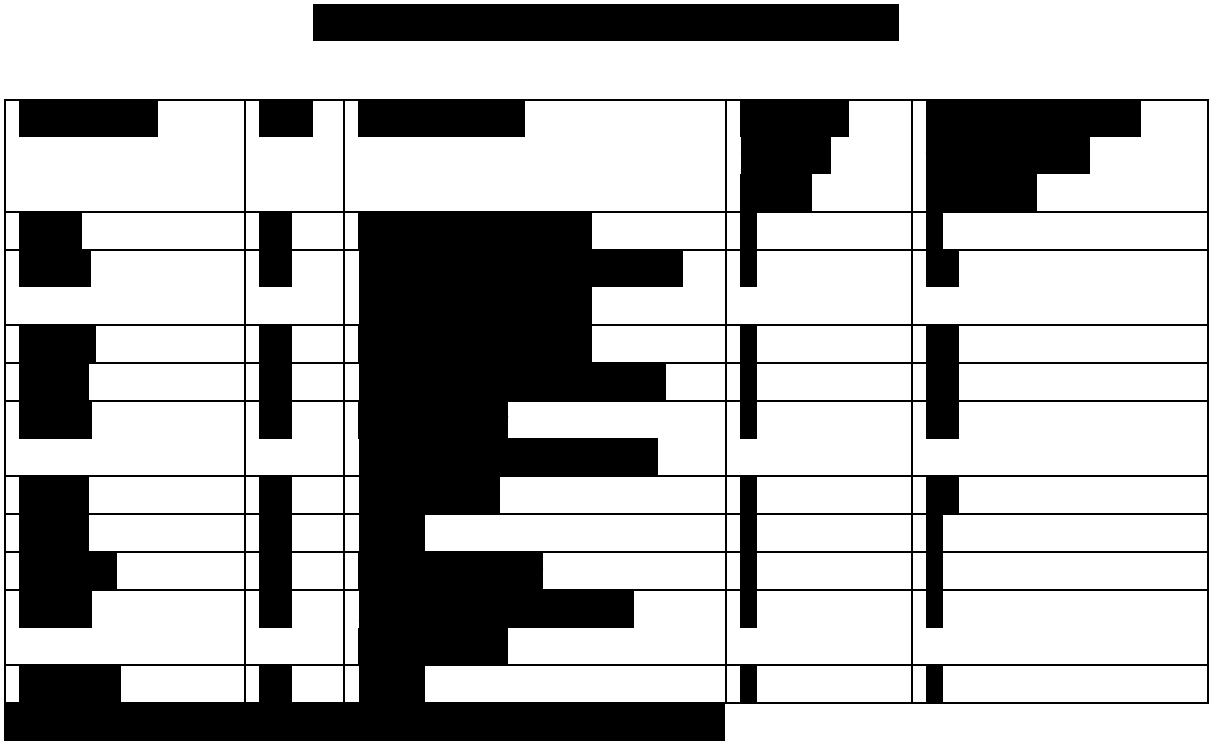

Appendix

The *Journal of Mental Health* is the target for submission of this article. It is a widely known journal, reaching more than 65 countries with popularity in the US and United Kingdom. It reports on some of the best evidence-based areas, creating access and communication regarding mental health research and practice. This journal aims to influence policy by reporting on non-traditional ways of working. This aim appeared to fit well with research based on a changing and developing IAPT system. The remit of this article of affecting policy can mean that this research may impact policy holders in the United Kingdom and help influence the developing system.

Consideration and deep reflection, went into choosing a journal for submission. A wide net was cast, exploring various avenues, considering the audience, relevance and criteria of numerous journals. It was important to choose a journal that would present the research in the best way, for the most appropriate audience. After several reviews and discussion in supervision, we explored the choice between the *Cognitive Behavioural Therapist*, and the *Journal of Mental Health*. The Cognitive Behavioural Therapist was a good choice as all CBT therapists working in IAPT receive monthly subscriptions as part of their professional registration. The Journal of Mental health was chosen as it would have a wider reach for various health professional working in IAPT. This journal might also allow for a more representative presentation of the research, rather than a focus on CBT.

To help this decision, I compared the manuscript to the journals aims and scopes. A review of recently published, articles was conducted. There were several articles on CBT, Counselling and therapy. There was a recent publication on IAPT Mackinnon and Murphy (2016) which was a qualitative study, with semi-structured interviews, exploring the experiences of individuals. This research appeared similar in these ways to the current study and it was felt it

was strongly tied to the current research interests of the journal. I identified at least five papers published in the last two years that were similar in aim and scope to this project.

I also asked my peers in the IAPT services and University for those who had heard about the two journals and the one chosen appeared to be more popular. *The Journal of Mental Health* was indexed on popular specific data bases such as PsychINFO.

One measure of the quality of a journal is its Journal Impact Factor (JIF). The Web of Knowledge's Journal Citation Reports ranks journals according to how often their content is cited by other authors representing the global impact and influence of a publication. The SCImago Journal Rank (SJR) indicator is a similar measure of a journal's impact. The impact factor of was reviewed, the 2016 Impact Factor was 1.941 (2017 Clarivate Analytics, Journal Citation Reports) and this was compared to similar journals in the field. I was also keen to target a journal with an online issue to decrease the likely-hood of publication delay.

Guidelines from the *Journal of Mental Health*

Manuscripts should be typed double-spaced (including references), with margins of at least 2.5cm (1 inch). The short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names, the exact word length of the paper and affiliations of authors and the address where the work was carried out. The corresponding author should be identified. All pages should be numbered. The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content. Authors will be asked to submit key words with their article, one taken from the pick-list provided to specify

subject of study, and at least one other of their own choice. Original articles should be no more than a total of 4000 words. We do not include the abstract, tables and references in this word count. Language should be in the style of the APA (see Publication Manual of the American Psychological Association, Fifth Edition, 2001).