Exploring the Personal and Systemic Factors Impacting on Wellbeing and Effective Working in Mental Health Professionals

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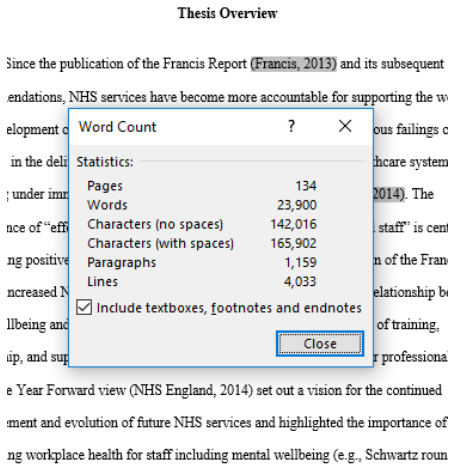

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Thesis Overview

Since the publication of the Francis Report (Francis, 2013) and its subsequent recommendations, National Health Service (NHS) services have become more accountable for supporting the wellbeing and development of their workforce. The Francis Report highlighted serious failings of services in the delivery of adequate and safe care in the context of a healthcare system working under immense clinical and financial pressures (NHS England, 2014). The importance of "effective care from caring, compassionate and committed staff" is central to supporting positive client outcomes (Francis, 2013, p.67). The publication of the Francis Report increased NHS senior managers' and services' awareness of the relationship between staff wellbeing and quality healthcare provision and also, the importance of training, leadership, and supervision in supporting staff to work effectively in their professional role. The Five Year Forward view (NHS England, 2014) set out a vision for the continued improvement and evolution of future NHS services and highlighted the importance of supporting workplace health for staff including mental wellbeing (e.g., Schwartz rounds, resilience training). The implementation of interventions to support staff wellbeing is supported by National Institute for Health and Care Excellence (NICE) (2009, 2015).

The drive for more caring and compassionate NHS services can be observed through both organisational and service-level changes implemented to support staff to work most effectively in their role. Within the literature little focus has been specifically given to mental health professionals (MHPs) regarding the personal and systemic factors impacting upon their wellbeing and ability to work effectively in their role.

This thesis synthesises and extends existing literature concerning the personal and systemic factors impacting upon MHPs based both within and outside of the NHS. It examines their experience of and ability to work with clients with complex mental health

difficulties, associated with presentations relating to psychological trauma in chapter one and eating disorders in chapter two. This thesis comprises two papers including a systematic literature review and an empirical research paper.

The systematic review was prepared for submission to Psychology and Psychotherapy: Theory Research and Practice. The systematic review implemented a robust, systematic search strategy to identify papers exploring the association between MHP attachment style and negative personal outcomes including burnout, compassion fatigue, and associated constructs. Nine peer-reviewed papers were deemed eligible for inclusion in the review. A quality assessment was completed for each paper. Findings identified an association between attachment insecurity, particularly attachment anxiety, and negative personal outcomes for MHPs in relation to clinical working with a range of complex mental health difficulties. Findings are discussed in relation to the impact of attachment style influencing MHPs' psychological wellbeing and the support required by them to reduce potential vulnerabilities to negative personal outcomes in relation to clinical working.

The empirical paper was prepared for submission to the British Journal of Psychology. The empirical paper used a grounded theory methodological approach with twelve eating disorder (ED) psychological therapists. A theoretical model was developed to comprehensively explain the processes in which personal and systemic factors enable therapists to work effectively with challenge in their role. Findings are discussed in relation to factors identified to support effective working for ED therapists and their experience of consequential job satisfaction, supporting them to continue working in the field, alongside the clinical implications of this.

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Chapter 1: Literature Review

A Systematic Review of Adult Attachment and Negative Personal Outcomes including Burnout, Compassion Fatigue and Associated Constructs in Mental Health Professionals [1]

Stephanie Keith

[1] This paper has been prepared for submission to Psychology and Psychotherapy: Theory, Research and Practice. The journal specifies a 6,000 word limit exclusive of abstract, reference list, figures and tables (see Appendix A for author guidelines).

Abstract

Purpose: Literature has explored the experience of mental health professionals (MHPs) in relation to a number of negative personal outcomes associated with clinical working. These include burnout, compassion fatigue, secondary traumatic stress (STS), vicarious trauma (VT) and shared traumatic stress (SdTS). However, few studies have explored the relationship between adult attachment and the experience of such outcomes for MHPs. This systematic review aimed to synthesise, describe and quality assess literature investigating the strength of association between adult attachment and negative personal outcomes in MHPs. Additionally, it aimed to report on the impact of differing levels of attachment security or styles.

Methods: Searches were conducted using PsycINFO, MEDLINE, CINAHL Plus, Web of Science, Academic Search Complete and Scopus databases alongside additional hand-searching to identify peer-reviewed empirical papers exploring the association between MHPs' attachment style and negative personal outcomes.

Results: Nine papers were identified. Attachment insecurity was positively associated with negative personal outcomes for MHPs. Although the strength of association differed between attachment styles, more evidence was identified to support an association between an anxious-ambivalent attachment style and negative personal outcomes. Clinical and research implications are discussed.

Conclusions: Although some inconsistencies across studies were identified, findings of this review suggest an important link between adult attachment and negative personal outcomes for MHPs.

Keywords: mental health professional, attachment, burnout, compassion fatigue, shared traumatic stress, vicarious trauma

Practitioner Points:

- Findings have important implications for MHPs' wellbeing.
- Attachment insecurity increases the likelihood of MHPs' experience of negative personal outcomes in relation to clinical working.
- Supervision and training should support the development of MHPs' awareness of personal attachment style to reduce experiences of negative personal outcomes.

Introduction

Mental Health Professionals

Mental health professionals (MHPs) now, more than ever, face greater occupational pressures in their role in relation to increased service demand and reduced provision, in the context of increasing complexity of mental health difficulties in society (NHS England, 2014). A major review of care at the Mid-Staffordshire National Health Service (NHS) hospital in the UK found that the identified serious failings were associated with a staff culture that lacked compassion and care (Francis, 2013). To tackle these failings the review recommended a drive toward compassion-focussed care to be achieved through investment in staff wellbeing across NHS services (Francis, 2013; Royal College of Physicians, 2015).

The demanding nature of their role leads MHPs, across a range of disciplines, susceptible to the development of negative outcomes upon social, physical and psychological wellbeing. These outcomes may lead to poor job satisfaction and a reduction in their ability to provide effective psychosocial, psychological or nursing interventions to clients (Leiper & Casares, 2000; Turgoose & Maddox, 2017). Research has often focussed on MHPs in theory development regarding constructs associated with negative personal outcomes for caring professionals (Figley, 2002; Stamm, 2002). This has been specifically true for those working with client trauma, defined as emotional or psychological disturbance in relation to a primary traumatic event.

Negative Personal Outcomes for Mental Health Professionals

The adverse impacts of working directly with client trauma has been documented in the literature for over 30 years. Negative personal outcomes are defined as negative psychological changes, including emotional (e.g., distress) and cognitive (e.g., beliefs, expectations, assumptions), and behavioural (e.g., reduced interpersonal functioning),

resulting from clinical work with trauma or suffering (Collins & Long, 2003). In the literature, key constructs used to conceptualise negative personal outcomes include professional burnout, compassion fatigue, secondary traumatic stress (STS) and vicarious trauma (VT) (Newell, Nelson-Gardell, & MacNeil, 2016).

Burnout is defined by Maslach, Jackson, and Leiter (1996) as three components including emotional exhaustion, depersonalisation, and reduced personal accomplishment. It is described as "a state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations" (Pines & Aronson, 1988, p. 9). Burnout can impact on the working environment through increased stress, reduced job performance and absenteeism (Pines & Maslach, 1978). Unlike burnout, compassion fatigue specifically refers to the emotional and psychological fatigue specifically experienced by caring professionals. Compassion fatigue is associated with the long-term application of empathy when working with individuals who are suffering or have experienced trauma (Figley, 1995; Joinson, 1992; Stamm, 2002). Compassion fatigue, experienced within a short time period, can lead to feelings of hopelessness and frustration, resulting in reduced work performance. Theories suggest that both the emotional exhaustion component of burnout and STS create compassion fatigue (Adams, Boscarino, & Figley, 2006; Stamm, 2010). STS has been defined as behavioural and emotional post-traumatic stress symptoms that are connected to patient suffering (Figley, 1995). The term STS is used interchangeably with VT, which is described as "transforming the inner experience of the therapist as a result of empathetic engagement" (McCann & Pearlman, 1990, p. 145). VT and STS are conceptualised as mirroring post-traumatic stress disorder (PTSD) symptoms experienced by the client that are in turn felt or experienced by caring professionals, leading to increased negative beliefs, cognitions and behaviours in the professional (Collins & Long, 2003; Pearlman & Saakvitne, 1995). The term shared traumatic stress (SdTS), formed through the experience of both PTSD

symptoms and STS, in recent years has been increasingly applied by researchers. This term articulates more effectively both the negative personal and professional impact of trauma as experienced by specific groups of MHPs working and living in the vicinity of traumatogenic environments (Altman & Davies, 2002; Tosone, 2006, 2012).

The literature widely acknowledges that these constructs, although distinctly different, are conceptually related and overlap (Figley, 1995; Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Adams et al.'s (2006) theoretical model suggests that both burnout and STS are components of compassion fatigue, which is supported by Stamm's compassion fatigue research (Stamm, 2002, 2010). More recently, Sabo (2011) questioned if compassion fatigue could be regarded as a precursor to VT. Despite differences in the conceptualisation of the above constructs, their interchangeable application in clinical practice and research makes navigating the literature challenging (Collins & Long, 2003; Najjar, Davis, Beck-Coon, & Carney Doebbeling, 2009; Sabin-Farrell & Turpin, 2003). Literature reviews have explored negative outcomes experienced by MHPs in relation to burnout and compassion fatigue and have acknowledged the aforementioned limitations of existing literature's ability to clearly define and apply these constructs (Paris & Hoge, 2010; Turgoose & Maddox, 2017; West, 2015). As the literature and clinical practice continues to develop, newly emerging constructs including empathy fatigue (Stebnicki, 2007) and SdTS (Tosone, 2012) evidence this evolving research area.

Attachment

Attachment theory proposes that individual attachment styles are formed through early childhood experiences and interactions with primary caregivers (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1980, 1988). Relational patterns learned from early

experiences toward others and oneself, conceptualised as internal working models (IWMs), impact upon thoughts, feelings, behaviours and also influence social and emotional development. Attachment styles are divided into categories of secure and insecure. The literature for both childhood and adult attachment categorises insecure attachment into avoidant and anxious-ambivalent styles (Ainsworth et al., 1978; Hazan & Shaver, 1987). In considering adult relationships Hazan and Shaver (1987) theorised that adult attachment styles closely resembled childhood attachment styles proposed by early attachment theorists. A four-category adult attachment model, based upon the dimensions of attachment-related anxiety and avoidance, regards attachment style as a combination of both negative and positive views about the self and others (Bartholomew & Horowitz, 1991; Brennan, Clark, & Shaver, 1998). This forms the basis of many self-report adult attachment measures and associates the terms preoccupied and fearful and dismissive with anxious and avoidant attachment styles, respectively (see Appendix B) (Schindler & Bröning, 2015). Self-report measures do not seek to identify specific attachment styles but consider them to exist on a continuum of security-insecurity in relation to attachment experience (Brennan et al., 1998).

IWMs support emotional regulation and enable engagement with coping strategies during times of stress, and are more frequently sought by individuals with an anxious-ambivalent attachment style (Hazan & Shaver, 1990). Attachment behaviours, activated under stress, increase an individual's sense of security in fear-provoking situations (Ravitz, Maunder, Hunter, Sthankiya, & Lancee, 2010; Simpson, Rholes, & Phillips, 1996) and determine their capacity for adaptive functioning. An anxious attachment style is associated with IWMs of the self whereas an avoidant attachment style relates to negative IWMs focused upon others (Manning, Dickson, Palmier-Claus, Cunliffe, & Taylor, 2017; Ravitz et al., 2010). Research has identified an association between attachment style and psychological wellbeing (Karreman & Vingerhoets, 2012; Mikulincer & Shaver, 2007), with insecure

attachment being associated with reduced wellbeing (Kafetsios & Sideridis, 2006; Lavy & Littman-Ovadia, 2011). Secure attachment is associated with increased wellbeing, job satisfaction and fewer work-related fears (Hazan & Shaver, 1990). Hazan and Shaver (1990) considered how attachment styles influence behaviours in the workplace, in line with (Bowlby, 1980, 1988) conceptualisation of child exploration in social situations in early years development.

Attachment and Negative Personal Outcomes for Mental Health Professionals

Ongoing clinical work with client trauma does not automatically increase individual vulnerability to burnout, compassion fatigue and STS (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Attachment plays a key role in regulating affect and other professional skills, including monitoring countertransferences with clients and maintaining appropriate boundaries (Bowlby, 1988; Bride, Radey, & Figley, 2007; Hazan & Shaver, 1987; Leiper & Casares, 2000; Parish & Eagle, 2003). The loss of such professional skills can be detrimental to MHPs' fitness to practice and their ability to seek timely support. Therefore, researchers remain curious about the personal factors that reduce this vulnerability in MHPs. Attachment literature regarding MHPs has focussed predominantly on psychological therapists and the impact of their attachment style on client outcomes (Daniel, 2006; Degnan, Seymour-Hyde, Harris, & Berry, 2016; Lingiardi, Muzi, Tanzilli, & Carone, 2017; Parpottas & Riccardo, 2015). Very little research has investigated the impact of attachment upon negative personal outcomes for MHPs, although research has investigated these outcomes independent of attachment (Collins & Long, 2003; Leiter & Harvie, 1996; Lim, Kim, Kim, Yang, & Lee, 2010; Paris & Hoge, 2010; Steel, Macdonald, & Schroder, 2018). STS was once considered an occupational hazard for health professionals but research has since demonstrated that

personal factors, such as attachment, can influence the impact of this (Adams et al., 2006). Attachment research has linked insecure attachment styles to higher levels of distress in clinical work for health professionals (Kim, Kashy, & Evans, 2007) and burnout in healthcare workers (Halpern, Maunder, Schwartz, & Gurevich, 2012). Although some studies have acknowledged the experience of STS-related symptoms in psychological therapists (Brady, Guy, Poelstra, & Brokaw, 1999; Bride et al., 2007; Schauben & Frazier, 1995), few have investigated the impact of this in association with adult attachment in MHPs.

A review reporting on the association between adult attachment and burnout and compassion fatigue in health and human service workers was recently published (West, 2015). It identified that higher levels of attachment insecurity were associated with higher levels of burnout and compassion fatigue. Specifically, that higher levels of attachment anxiety were associated with burnout and compassion fatigue. In contrast to the reported review, West (2015) did not specifically focus on MHPs and investigated burnout and compassion fatigue only.

Research Question and Aims

This review aimed to provide a comprehensive review and synthesis of existing literature examining the strength of association between adult attachment and negative personal outcomes experienced by MHPs in relation to their professional role. This review explored the following question; 'What is the association between mental health professionals' attachment styles and negative personal outcomes including professional burnout, compassion fatigue and associated constructs in relation to clinical working?' In particular, it aimed to report on findings regarding levels of attachment security or styles impacting on the experience of a range of negative personal outcomes and to highlight clinical implications that will enable the robust support of MHP wellbeing. This review

included multiple constructs associated with negative personal outcomes due to the overlap in conceptualisations and inconsistent and interchangeable use in the literature associated with this phenomenon (Elwood, Mott, Lohr, & Galovski, 2011; Morse et al., 2012; Newell et al., 2016). The researcher identified no systematic review investigating attachment style and negative personal outcomes in MHPs and therefore a synthesis of existing research was indicated.

Method

Before the review was undertaken, a protocol was submitted to the Prospero register (www.crd.york.ac.uk/PROSPERO) [CRD42017077184]. This protocol was updated to accurately reflect review undertakings.

Eligibility Criteria

Studies were included if the following inclusion criteria were met: 1) MHP as participants; 2) measure of MHP attachment; 3) measure of negative personal outcome for MHP; 4) quantitative study; 5) association analysis conducted; 6) written in English; 7) any country of origin and 8) published in a peer-reviewed journal. Studies were excluded if they did not meet the above criteria or were review papers or case studies. MHP was defined as either a qualified or semi-qualified professional engaging in direct work with individuals presenting with mental health difficulties, offering appropriate intervention to support presenting difficulties across a range of settings. Negative personal outcome was defined as negative psychological outcomes experienced by MHPs in relation to their professional role, in the form of burnout, compassion fatigue and other closely associated constructs as defined by existing literature.

Information Sources

Searches were conducted using six databases: PsycINFO (1887-current), MEDLINE (1948-current), CINAHL Plus (1937-current), Web of Science (1898-current), Academic Search Complete (1887-current) and Scopus (1823-current) using the EBSCOhost interface, where applicable. These databases yielded the highest number of results for applied search terms. An initial search was conducted on 26th November 2017. Attempts to identify additional eligible publications included hand-searching of reference lists, journals, and

correspondence with authors. Reference chaining of papers included in the review, relevant dissertations and a highly relevant systematic review (West, 2015) identified within database searching was conducted. The journals, in which eligible papers included in this review were published, were searched from dates 2007-2017. Authors of included papers were contacted (30th Nov-11th December 2017) regarding any eligible published or unpublished research (see Appendix C). An updated database search was conducted on 12th April 2018, alongside a Google Scholar search, to ensure any eligible, recently published articles had been identified (see Appendix D).

Search Strategy

The following search terms were applied to each database: (therapist* OR counsellor OR counselor OR psychotherapist* OR psychologist* OR psychiatrist* OR clinician* OR "mental health professional*" OR "mental health personnel" OR "mental health worker*" OR "psychiatric nurs*" OR "mental health nurs*") AND attachment* AND (burnout OR "burn out" OR "compassion fatigue" OR "compassion satisfaction" OR "vicarious trauma*" OR "empathy fatigue" OR "secondary trauma*" OR "shared trauma*").

No limiters were applied to database searches. A controlled vocabulary search was considered for all databases following Cochrane guidelines (Higgins & Green, 2011). Alternative controlled vocabulary search terms were identified for one database (see Appendix E).

Data Selection

All references from database searches were exported into Endnote, a reference management software package, where duplicate references were removed. An initial

screening of titles and abstracts was conducted by the researcher to determine eligibility for inclusion. A second rater screened a 50% selection of the titles and abstracts of all identified references to control for screening reliability. Remaining articles were read in full by the researcher. Any discrepancies regarding the eligibility of papers for inclusion, between the researcher and second rater, were discussed until consensus was reached. See Figure 1 for the data selection process.

Risk of Bias

The researcher and second rater independently conducted a quality assessment using a tool widely implemented by researchers for the assessment of quantitative studies in systematic reviews from the Agency for Healthcare Research and Quality (AHRQ) (Taylor, Hutton, & Wood, 2015; Williams, Plassman, Burke, Holsinger, & Benjamin, 2010). This tool measures methodological quality and report writing across 9 specific areas, allowing for comparison of risk of bias between quantitative, observational studies (Cherry, Taylor, Brown, Rigby, & Sellwood, 2017). Adaptations to this tool included removing two questions of no relevance to the current review regarding longitudinal and control group studies (see Appendix F).

Data Extraction

In order for relevant data to be sufficiently extracted and captured, a data extraction form was piloted and then implemented. The form captured the following information. Study characteristics included design, location, and sampling method. Participant characteristics included sample size, gender, age, ethnicity, mental health population, professional qualifications, attachment measure and negative personal outcome measure. Main findings

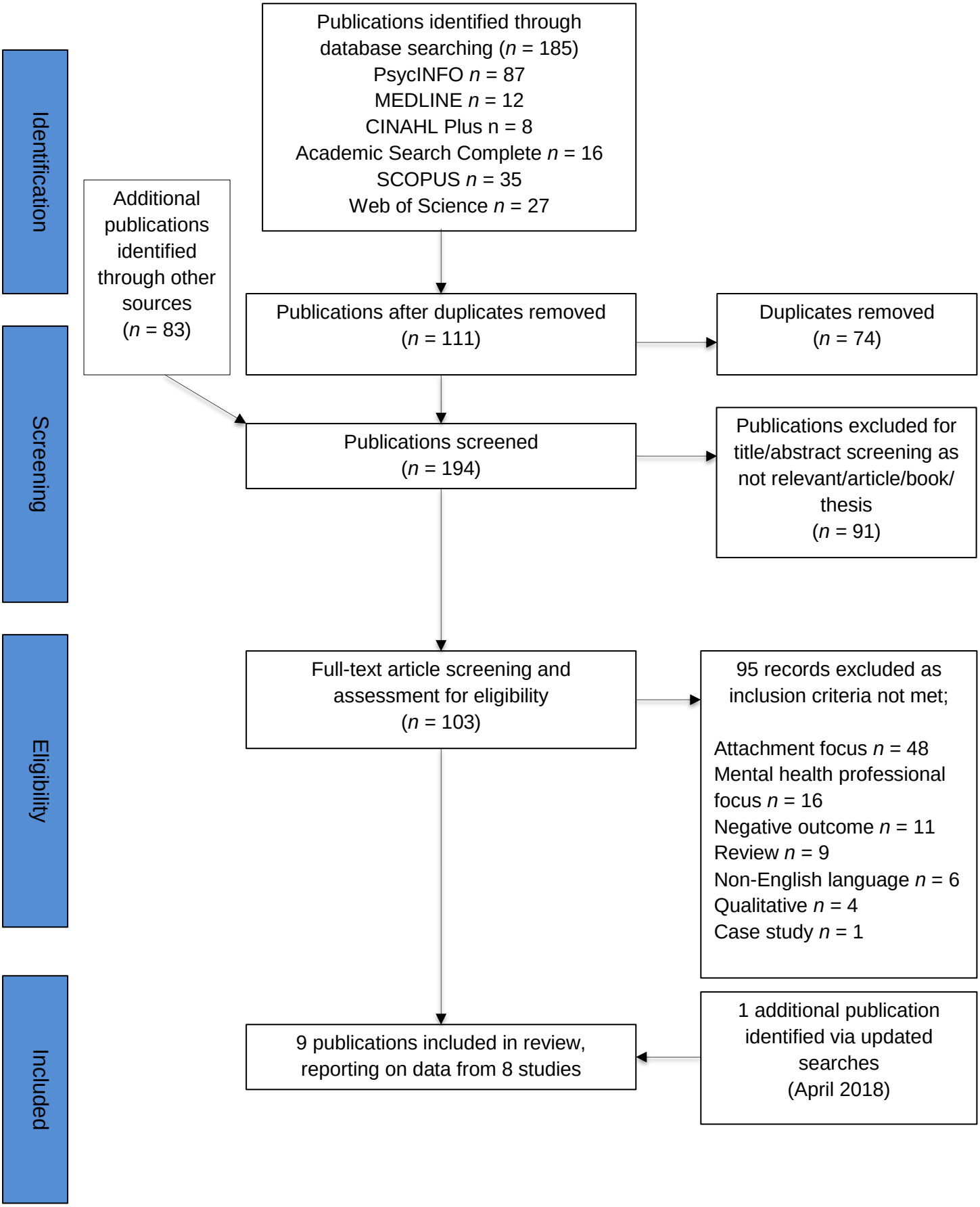

Figure 1. Flowchart of included studies (adapted from Moher, Liberati, Tetzlaff, Altman, and Group (2009)

included negative personal outcome and attachment variables, findings and control variables. One author provided additional data analysis.

Method of Synthesis

Studies eligible for inclusion measured a number of constructs relating to negative personal outcomes in association with attachment, using a number of quantitative measures. Due to the heterogeneous nature of data gathered from these studies, a narrative, qualitative synthesis of results was deemed most appropriate (Margaliot & Chung, 2007).

Results

A total of 185 records were identified through database searching. After duplicate records were removed this total reduced to 111 records. An additional 83 records were identified through correspondence with authors, journal and reference list searching. A total 194 records titles and abstracts were screened for suitability, which led to the exclusion of 91 records. A total 103 publications were read in full by the researcher and 95 were excluded for not meeting the inclusion criteria (see Figure 1). One additional record was identified through updated searches. A total nine papers relating to eight independent samples were included in the review. As the same sample was described in papers by Tosone, Bettmann, Minami, & Jasperson (2010) and Tosone, McTighe, Bauwens, & Naturale (2011) these studies are reported together in the study characteristics table.

Study Characteristics

Study details can be found in Table 1. All studies were cross-sectional. Although men were represented across samples, the majority reported on women with one study reporting exclusively on women therapists (Marmaras, Lee, Siegel, & Reich, 2003). This could be considered representative of health professionals generally (The King's Fund, 2013). Samples were recruited from a range of locations including Ireland, UK, USA, Israel, and Hawaii. The age of samples varied widely from 20 to 69, however not all studies reported this information. MHP professional training varied ranging from no formal education to doctoral level qualification including those from predominantly psychology, nursing, and social work backgrounds. Two studies included samples of semi-qualified MHPs working under clinical supervision (Burrell et al., 2009; Zerach, 2013). All studies reported on MHPs working with mental health populations with experienced psychological trauma. Two studies

specified MHPs working with adult clients and two reported specifically on child and family and children looked after populations.

Summary of Measures

Attachment measures. Studies employed a range of quantitative, self-report measures of attachment. Attachment, based on theoretical underpinnings, was measured along dimensions of avoidance and ambivalence (Hazan & Shaver, 1987; Simpson et al., 1996) (*n*=3) and avoidance and anxiety (Brennan et al., 1998) (*n*=5). One study applied a measure based on Bartholomew and Horowitz's (1991) categorical model of secure, fearful-avoidant, dismissive-avoidant and preoccupied attachment styles. Higher dimensional scores are indicative of attachment insecurity and lower scores indicative of attachment security. To synthesise findings based on the literature (Ainsworth et al., 1978; Brennan et al., 1998; Hazan & Shaver, 1987), findings are reported in relation to levels of avoidant and anxious-ambivalent attachment and specific attachment styles as indicated by studies.

Negative personal outcome measures. Studies employed a range of specific construct-related quantitative, self-report measures for negative personal outcomes including burnout, compassion fatigue, VT, and SdTS. Higher scores on sub-scales indicated higher levels of negative personal outcome. Two validation studies combined scores from validated and reliable PTSD and compassion fatigue self-report measures to quantify SdTD (Tosone, McTighe, & Bauwens, 2015; Tosone et al., 2011).

Risk of Bias

Individual studies. The results of a quality assessment using the AHRQ (Williams et al., 2010) can be found in Appendix F. The appropriateness of analyses, for three papers (Burrell et al., 2009; Hartley, Jovanoska, Roberts, Burden, & Berry, 2016; Zerach, 2013),

Table 1
Study Characteristics

Author (year)	Study characteristics: Design	Location	Sampling method	N	Women, n (%)	Age mean (SD)	Participant characteristics: Ethnicity, n (%)	Mental health population	Qualification (%)	Attachment measure	Negative personal outcome measure
Carr & Egan (2017)	Cross-sectional	Ireland	Quasi-random sampling	137	112 (81.75)	52 (9.9)	n/s	n/s	Psychological therapists (100)	AAQ	Burnout MBI-HSS
Burrell et al. (2009)	Longitudinal [a]	Hawaii	Convenience sampling	62	61 (98)	20-29 (20) 30-39 (36) 40-49 (29) 50-59 (12) 60-69 (3)	Asian (42) Native Hawaiian/Pacific Islander (27) White (26) Other (5)	Child & Family (Maternal mental health)	Trained paraprofessional home visitors: High school or > (49) Bachelors degree in social sciences/nursing (32) Associated degree (19)	ASQ	Burnout MBI
Hartley et al. (2016)	Cross-sectional	UK	Convenience sampling	50	33 (66)	37.5 (10.64)	n/s	Adult: Psychosis-inpatient setting	Mental health nurse (25) Support worker (20) Psychologist (18) Occupational therapist (15) Psychiatrist (10)	The Attachment Measure	Burnout MBI-HSS

Marmaras et al. (2003)	Cross-sectional	USA	Convenience sampling	375	375 (100)	25-35 (8) 36-45 (20.5) 46-55 (48.3) 56-65 (20.3) 66+ (2.9)	Caucasian (93.6) Hispanic (2.4) Native American (1.6) Asian (1.1) African American (0.8%) Other (0.5%)	Adult: Trauma – survivors of sexual abuse, war	Psychological therapists: Psychology; PhD (72.5) MA/MS (11.7) PsyD (9.6) EdD (5.1) MD (1.1%)	RQ	<u>Vicarious Trauma</u> TSI-Revision L IES-R
Tosone et al. (2010) Tosone et al. (2011)	Cross-sectional	USA	Quasi-random sampling	481 [b]	383 (79.6)	59.83 (9.3)	White (92.7) Hispanic/Latino (1.9) Mixed race (1.5) African American/Black (1.2) Asian/Pacific Islander (0.6) Other (0.6)	Trauma – inc. survivors of terrorism, man-made disaster	Social Workers: Masters (84) Doctorate (16) Formal therapy training (96.5) (*psychoanalytic, CBT, systemic training*)	AAQ	<u>Compassion Fatigue</u> ProQOL: CFS-R-IV* <u>Shared Traumatic Stress</u> ProQOL: CFS-R-IV* PCL-C
Tosone et al. (2015)	Cross-sectional	USA	Quasi-random sampling	244	200 (82)	48 (13)	White (86)	Trauma – inc. survivors of natural disaster	Social Workers; Mental health: Masters (83) Doctorate (17) Formal therapy training (n/s)	AAQ	<u>Shared Traumatic Stress</u> ProQOL: CFS-R-IV* PCL-C

Racanelli (2005)	Cross-sectional	USA & Israel	Snowball sampling	66	42 (62.1)	n/s	n/s	Trauma – terrorism man-made disaster	Clinical Psychologist (30.3) Social worker (39.7) Psychiatrist (4.5) Counselling Psychologist (7.6) Mental Health Nurse (7.6) Family therapist (1.5) Other (art therapist/psychoanalyst, other psychologist) (10.6)	ECR-R	Compassion Fatigue ProQOL: CFS-R-III
Zerach (2013)	Cross-sectional	Israel	Convenience sampling	221 [c]	110 (49.77)	26.03 (4.02)	n/s	Children Looked After (Emotional and behavioural difficulties – residential setting)	Support workers; Undergraduate degree (45.2) No therapeutic training (32.6) No formal education (11.3) Certificate (7.7) Graduate (3.2)	ECR	Compassion Fatigue ProQOL: CFS -V

a = cross-sectional for purposes of review (baseline data extracted only) b = Total sample: data extracted for *n*=305 n/s = not stated
c = Total sample: data extracted for residential care worker population *n*=147 * = Studies implementing compassion fatigue/STS subscale

AAQ= Adult Attachment Questionnaire (Simpson, Rholes & Phillips, 1996); ASQ= The Attachment Style Questionnaire (Feeney, Noller, & Hanrahan, 1994); The Attachment Measure (Berry, Wearden, Barrowclough, & Liversidge, 2006); RQ= The Relationship Questionnaire (Bartholomew & Horowitz, 1991); ECR-R= Experiences in Close Relationships Scale-Revised (Fraley, Waller & Brennan, 2000); ECR= Experiences in Close Relationships Scale (Brennan, Clark, & Shaver, 1998); MBI-HSS= Maslach Burnout Inventory for Human Services (Maslach & Jackson, 1996); MBI= Maslach Burnout Inventory (Maslach, Jackson & Leiter, 1996); TSI-Revision L= The Trauma Stress Institute Belief Scale–Revision L (Pearlman & Saakvitne, 1995); IES-R= The Impact of Event Scale–Revised (Weiss & Marmar, 1995); PCL-C = PTSD Checklist-Civilian Version (Ruggiero, Del Ben, Scotti & Rabalis, 2003); ProQOL: CFS-R-IV= Professional Quality of Life Scale: Compassion Fatigue and Compassion Satisfaction subscales revised (fourth version) (Stamm, 2002);; ProQOL: CFS-R-III= Professional Quality of Life Scale: Compassion Fatigue and Compassion Satisfaction subscales revised (third version) (Stamm, 2002); ProQOL: CFS-V = Professional Quality of Life Scale: Compassion Fatigue and Compassion Satisfaction subscales (Stamm, 2010)

was assessed based on extracted data. Burrell et al.'s (2009) study reports a longitudinal design but as only baseline data were extracted it was quality assessed as cross-sectional.

Common methodological limitations included participant recruitment, sample size, outcome measures, confounding variables and missing data, the details of which can be found below. In particular, the consideration of the appropriate use of outcome measures, analytical approach and control of confounding variables, informed by findings from the quality assessment, supported the interpretation of findings. Specifically, the critical appraisal of study findings informed the researcher's assessment of the magnitude of reported effect sizes as well as clinical implications. Biases existed concerning convenience sampling reducing the ability of included studies to recruit a representative participant sample. Although some studies attempted to control for this, using quasi-sampling methods, this bias may have impacted upon the generalisability of findings. Only one study reported power calculations (Tosone et al., 2010), which made assessing the appropriateness of analysis difficult and increased remaining studies' vulnerability to type I errors. All studies used self-report measures. To control for researcher biases most studies reported questionnaire distribution using online and postal methods (*n*=6). However, questionnaires administered by researchers in other studies may have increased such biases, in addition to social desirability potentially influencing questionnaire completion (Burrell et al., 2009; Hartley et al., 2016; Zerach, 2013). The measurement of attachment and negative personal outcomes was undertaken using a number of validated measures. All but two studies (Marmaras et al., 2003; Racanelli, 2005) reported internal reliability score for measures. Hartley et al. (2016) reported poor internal reliability scores (<.7) for the MBI-HSS (Maslach & Jackson, 1996). The measurement of SdTS was undertaken with a tool developed by authors (Tosone et al., 2015; Tosone et al., 2011) using existing validated and reliable measures for PTSD and compassion fatigue, with empirical justification. However, the validity of the PTSD measure (Ruggiero,

Del Ben, Scotti, & Rabalais, 2003) may have been compromised as minor adjustments were made to the Likert scale. Seven studies implemented full measures for negative personal outcomes, however, three studies (Tosone et al., 2010; Tosone et al., 2015; Tosone et al., 2011) measured compassion fatigue using the compassion fatigue/STS sub-scale of the ProQOL-CFS-R-IV (Stamm, 2002) with empirical justification. Five studies attempted to control for possible confounding demographic variables (e.g., exposure to client trauma) and two studies controlled for covariates associated with negative personal outcomes using regression analyses (Tosone et al., 2015; Tosone et al., 2011). However, studies implementing correlational analyses could not control for such variables (Burrell et al., 2009; Hartley et al., 2016; Marmaras et al., 2003; Zerach, 2013). Therefore, associations identified in these studies may relate to other variables that were not controlled for. Only two studies discussed missing data (Carr & Egan, 2017; Tosone et al., 2015), therefore for the majority of papers (*n*=7), it was difficult to interpret if missing data had impacted upon reported findings.

Across studies. As this review specified the inclusion of peer-reviewed papers it is possible that findings are subject to publication bias. Inclusion criteria specified the inclusion of papers written in English, which could have led to cultural biases in the reporting of findings.

Study Outcomes

The main findings from nine studies included in the review can be found in Table 2. Studies implemented a cross-sectional design to analyse the strength of association between attachment and constructs associated with negative personal outcomes, including burnout (*n*=3), compassion fatigue (*n*=3), VT (*n*=1) and SdTS (*n*=2) in MHPs.

Burnout. Three studies reported on associations between levels of attachment anxiety and avoidance and burnout, using burnout-specific measures (Burrell et al., 2009; Carr & Egan, 2017; Hartley et al., 2016). All studies identified significant positive associations

Table 2
Main Findings

Authors (year)	Negative personal outcome variable	Attachment variable	Bivariate association		Multivariate association		Control variables
			Statistical analysis	Effect size	Statistical analysis	Effect size	
Carr & Egan (2017)	Burnout						
	EE	Anxiety		-	Hierarchical multiple regression	β = .22*	Age, gender, years worked as a therapist, qualification level, perceived social support, other attachment style
		Avoidance		-		β = .06	
	Depersonalisation	Anxiety		-		β = .16	
		Avoidance		-		β = .23*	
Burrell et al. (2009)	Burnout						
	EE	Anxiety		r = .35*		-	n/a
		Avoidance		r = .24		-	
	Depersonalisation	Anxiety	Pearson's correlations	r = .36**		-	
		Avoidance		r = .12		-	
	Personal accomplishment	Anxiety		r = -.33*		-	
		Avoidance		r = -.22		-	
Hartley et al. (2016)	Burnout						
	EE	Anxiety		r = .30*		-	n/a
		Avoidance	Pearson's correlations	r - .18		-	
	Depersonalisation	Anxiety		r = .44**		-	
		Avoidance		r = 11		-	
	Personal accomplishment	Anxiety		r = .21		-	
		Avoidance		r = .06		-	
Marmaras et al. (2003)	Vicarious trauma						
	Cognitive - disrupted cognitive schemas	Secure	Pearson's correlations	r = -.34**	Hierarchical multiple regression	β = -.08	Other attachment styles
		Fearful-avoidant		r =.42**		β = .30**	
		Dismissive-avoidant		r = .20**		β = .13**	
		Preoccupied		r =.36**		β = .27**	
		Secure		r = -.20**		β = .00	
	Behavioural - intrusion, avoidance & hyperarousal	Fearful-avoidant		r = .27**		β = .21**	
		Dismissive-avoidant		r = .23**		β = .20**	

		Preoccupied		r =.23**		β = .18**	
Tosone et al. (2010) [a]	Compassion fatigue						
		Ambivalence		-	Hierarchical multiple regression	β = .09**	Number of years experience, percentage of time with clients addressing trauma, other attachment style, therapist witnessed World Trade Centre attacks directly
		Avoidance		-		β = .18**	
Tosone et al. (2011) [a]	Shared traumatic stress	Ambivalence		-	Path analytic modelling	β = 19*	Exposure to traumatic life events, other attachment style, enduring distress attributed to World Trade Centre attacks
		Avoidance		-		β = .20*	
Tosone et al. (2015)	Shared traumatic stress	Ambivalence		-	Path analytic modelling	β = .29*	Exposure to traumatic life events, other attachment style, enduring distress attributed to Hurricane Katrina.
		Avoidance		-		β = .21*	
Racanelli (2005)	Compassion fatigue						
	Compassion fatigue	Anxiety		-	Simultaneous regression	β = .18 [b]	Country of employment
		Avoidance		-		β = -.01	
	Burnout	Anxiety		-		β = .39** [b]	
		Avoidance		-		β = .27*	
	Compassion satisfaction	Anxiety		-		β = -.39** [b]	
		Avoidance		-		β = -.22	
Zerach (2013)	Compassion fatigue					-	n/a
	Compassion fatigue	Anxiety		r =. 45** [c]		-	
		Avoidance	Pearson's Correlation	r = .08 [c]		-	
	Burnout	Anxiety		r = .26** [c]		-	
		Avoidance		r = .25** [c]		-	
	Compassion satisfaction	Anxiety		r = -.26** [c]		-	
		Avoidance		r = -.24** [c]		-	

* $p < .05$ ** $p < .01$ n/a = not applicable EE = emotional exhaustion r = correlation coefficient β = standardised regression coefficient

[a] = data analysed from same sample, different analysis [b] = analysis extracted from dissertation [c] = data obtained from author

between attachment anxiety and emotional exhaustion, which held when variables including age, gender, years working as therapist, qualification level and perceived social support were controlled for (Carr & Egan, 2017) (β=.22; r =.30 -.35). This finding was also upheld in studies implementing the burnout sub-scale of the ProQOL, representative of emotional exhaustion (Racanelli, 2005; Zerach, 2013), as reported below. Two studies (Burrell et al., 2009; Hartley et al., 2016) identified significant positive correlations between levels of attachment anxiety and depersonalisation (r =.36 - .44). Carr and Egan (2017) did not identify a significant association in a regression analysis. Results for personal accomplishment were mixed. Burrell et al. (2009) reported a significant negative correlation between attachment anxiety and personal accomplishment (r = -.33). This finding was not supported by Hartley et al. (2016). None of the studies, apart from Carr and Egan (2017) for depersonalisation (β = .23), identified significant positive associations between the burnout sub-scales and attachment avoidance. Overall, effects of attachment anxiety were slightly larger (β=.22; r =.30 - .44) than attachment avoidance (β=.23) for burnout sub-scales.

Compassion fatigue. Three studies reported on associations between attachment anxiety, ambivalence, and avoidance and compassion fatigue (Racanelli, 2005; Tosone et al., 2010; Zerach, 2013). Findings were based on the application of a professional quality of life measure widely implemented in compassion fatigue research. Sub-scales included burnout, compassion satisfaction, and compassion fatigue or STS. This review refers to the latter subscale as measuring compassion fatigue, as defined by Stamm (2010). However, studies named this subscale interchangeably.

Findings for compassion fatigue were inconsistent. Two studies investigated associations between compassion fatigue and attachment anxiety and attachment avoidance. Zerach (2013) identified a significant positive correlation between attachment anxiety and compassion fatigue (r = .45), which Racanelli (2005) did not when controlling for additional

variables. Neither study found significant associations between attachment avoidance and compassion fatigue. Interestingly, Tosone et al. (2010) identified, when controlling a number of demographic variables, a significant positive association between attachment ambivalence and attachment avoidance with compassion fatigue. However, these effect sizes were modest (β=.09 - .18). Both studies investigating the relationship between attachment anxiety and attachment avoidance, and burnout, found significant positive associations (Racanelli, 2005; Zerach, 2013). These effects were small to medium and were higher for attachment anxiety (r = .26; β=.39) (Cohen, 1998) than for attachment avoidance (r = .25; β= .27). Both studies also identified significant negative associations between attachment anxiety and compassion satisfaction (r = -.26; β= -.39). This finding was only replicated for attachment avoidance by Zerach, (2013) (r = -.24). Overall, effect sizes for associations between attachment anxiety and attachment ambivalence and compassion fatigue, burnout and compassion satisfaction were small to medium (β=.09 - .39; r =.26 - .45), which were larger than attachment avoidance (β =.18 - .27; r = .24 - 25).

Shared traumatic stress. Two studies (Tosone et al., 2015; Tosone et al., 2011) identified significant positive associations for both attachment ambivalence (β= .19 - .29) and attachment avoidance (β= .20 - .21), and SdTS, when controlling for a number of variables. When resilience mediated the effects of attachment on SdTS, the difference in effects were negligible (β=.03 - .05). Therefore studies concluded that attachment had a direct rather than an indirect effect on SdTS.

Vicarious trauma. Marmaras et al. (2003) identified significant positive associations between all categories of insecure attachment styles, including fearful-avoidant, dismissive-avoidant and preoccupied, and VT. VT was determined by measures of both behavioural and cognitive disturbance. Effect sizes were similar for both fearful-avoidant (β=.21- .30; r = 27 - .42) and preoccupied attachment (β=.18 - .27; r = .23 - .36). Higher effects for cognitive

disturbance was identified across insecure attachment styles (β=.13 - .30; r = .20 - .42), when compared with behavioural disturbance (β=.18 - .21; r = .23 - .27). Non-significant regression analyses findings identified that secure attachment was not predictive of VT across both measures. However, correlational analysis identified significant negative correlations between secure attachment and VT measures (r = -.20 - -.34). Overall, effect sizes for VT ranged from β= .13 - .30; r = .20 - .42.

Discussion

This review aimed to investigate the strength of association between adult attachment in MHPs and negative personal outcomes experienced in relation to their professional role. Positive associations were identified between attachment insecurity and negative personal outcomes including burnout, compassion fatigue, VT, and SdTS. Findings were consistent with a range of MHPs working across different settings with different client populations. Marmaras et al. (2003) findings suggest that secure attachment is associated with lower levels of VT. Overall, findings suggest an association between attachment insecurity and negative personal outcomes for MHPs in relation to their professional role. Previous research supports these findings through identifying that attachment security enables more adaptive responses to stress through lowering vulnerability to negative personal outcomes and increasing psychological wellbeing (Kafetsios & Sideridis, 2006; Kessler et al., 1995; Lavy & Littman-Ovadia, 2011; Mikulincer & Shaver, 2007).

Review findings indicate differences in the strength of association between different attachment styles and negative personal outcomes. This suggests that attachment style may influence the degree to which MHPs experience negative personal outcomes. Attachment style could impact upon an individual's perception of limited available social support (e.g., negative view of self or others) available to them both within and outside of the workplace. This, in addition to an inability to seek social support to process and regulate psychological experiences, in relation to clinical work, may impact on experienced negative personal outcomes (Hazan & Shaver, 1987). However, results are inconsistent regarding the specific insecure attachment style most attributable to negative personal outcomes. Overall, findings indicate that MHPs identifying with higher levels of attachment anxiety or attachment ambivalence as most likely to experience negative personal outcomes. These findings are supported by both attachment theory (Bowlby, 1980, 1988; Hazan & Shaver, 1987) and West

(2015). Interestingly, although inconsistent, findings provide evidence to suggest that both higher levels of attachment anxiety or attachment ambivalence and attachment avoidance are associated with negative personal outcomes for MHPs. Although studies discussed findings in relation to separate attachment styles, Marmaras et al.'s (2003) findings further strengthen them. Higher effect sizes for fearful-avoidant attachment style (i.e., higher attachment anxiety and avoidance) associated with VT, suggest that both insecure attachment styles are significant in the experience of negative personal outcomes.

Adult attachment theory suggests that an anxious attachment style (e.g., negative self IWMs) could reduce MHPs' ability to seek emotional support for work-related incidents, due to a fear of rejection from others (e.g., 'I should be able to cope') (Bartholomew & Horowitz, 1991). It could be hypothisised that these individuals may experience negative personal outcomes if they are unable to regulate their emotions or get their attachment needs met through support from others (e.g., seeking reassurance). Workplace support may be prevented or delayed due to lack of supervisor availability or an individual's reluctance to seek support due to a sensitivity of rejection from others. Hazan and Shaver (1990) identified that adults with an anxious-ambivalent attachment style viewed professional work as an opportunity to satisfy their attachment needs, through praise or positive responses. Therefore, the opposite of such experiences could also potentially lead to negative psychological experiences. Conversely, individuals with an avoidant attachment style hold negative IWMs of others (Bartholomew & Horowitz, 1991). As a consequence, they value independence in problem-solving and avoid seeking support as a strategy to regulate their emotions (e.g., 'I can manage'). Therefore, clinically-related emotional experiences, if overwhelming for such MHPs, may be suppressed and remain unresolved, resulting in negative personal outcomes.

The overall findings of this review were not replicated by Carr and Egan (2017) or Racanelli (2005). Neither study identified higher levels of attachment anxiety to predict

depersonalisation or compassion fatigue. These findings may be reflective of the participant sample. However, these studies did not control for variables significantly associated with attachment or negative personal outcome constructs (e.g., resilience), which may have influenced these findings. Associations between attachment avoidance and negative personal outcomes revealed inconsistencies. Findings were more consistent, despite modest effects, for multivariate analyses, where additional variables were controlled (Marmaras et al., 2003; Racanelli, 2005; Tosone et al., 2010; Tosone et al., 2015; Tosone et al., 2011). Three of these studies specifically reported on MHPs living and working within a society that has survived trauma in the context of natural or man-made disasters. Their findings suggest that a higher level of attachment avoidance was associated with negative personal outcomes. This attachment style may have been protective from client expressed emotion, but may have also prevented MHPs from seeking support in a timely manner, leaving them vulnerable to the development of negative personal outcomes (Bowlby, 1980; Hazan & Shaver, 1987). Their findings suggest that higher levels of attachment insecurity lead to increased MHP vulnerability of negative personal outcomes as client trauma further impacts upon their personal trauma experiences (Bowlby, 1980; Hazan & Shaver, 1990).

Strengths and Limitations

Individual studies. Overall, the quality of studies varied. Studies rated as higher quality provided information on sample size, demographics, and information regarding attempts to control for researcher effects, which are important in determining the suitability of analysis applied and generalisability of findings. A strength of included studies was that they all implemented cross-sectional designs, which is most appropriate for review aims. Also, studies sampled a range of MHPs across a number of settings, which broadened the scope of review findings.

Lower-rated studies failed to report on the aforementioned factors. Studies' inability to report reliability scores for their attachment or negative personal outcome measures created difficulties in determining confidence in findings. The majority of studies did not provide sample size information. Studies also mainly implemented convenience sampling techniques, which may have increased the bias of MHPs with experience of negative personal outcomes wanting to participate. Such sampling approaches also made it unlikely that any study was able to recruit an unbiased cohort for data collection, which has implications for the generalisability of findings. Although not set within the inclusion criteria, the majority of reviewed studies reported on the negative personal outcomes for MHPs working with client trauma across a range of populations. This may have also impacted upon the generalisability of findings to MHPs working with clients presenting with complex mental health difficulties who do not present with overt trauma presentations (e.g., eating disorders, alcohol or substance misuse) as such populations might elicit different personal responses in this professional group. Although six studies attempted to control for confounding variables, three studies did not apply multivariate data analysis to appropriately control for this. Correlational findings could be suggestive of variables other than attachment influencing the experience of negative personal outcomes for MHPs.

Review process. It is acknowledged that this review has a number of limitations. It included studies only written in English. Also, only peer-reviewed publications were included, meaning that findings could be subject to publication bias. The scope of the review was broad and included a range of constructs relating to negative personal outcomes meaning that the heterogeneity of findings could not be synthesised with the application of meta-analytic techniques. This would have enabled a more in-depth analysis and synthesis of findings. The review investigated a number of constructs, associated with negative personal outcomes. Research is inconsistent applying these constructs appropriately (Sabin-Farrell &

Turpin, 2003). Therefore, the synthesis and interpretation of review findings was complex due to a number of measures implemented to quantify these constructs. Difficulties around the synthesis were further compounded as studies used a range of attachment measures. These measures were based on different theories of attachment (i.e., attachment as either dimensional or categorical) and measured attachment in either general or romantic relationships (Ravitz et al., 2010). However, a number of interesting findings were identified.

The review's main strength was that it implemented a comprehensive search strategy. Search terms were well considered and finalised through consultation with an information specialist. Extensive additional searching and correspondence with authors were undertaken alongside database searching, which was updated prior to completion. A second rater was involved both in the data selection and quality assessment stages of this review to ensure reliability. Given the application of this search strategy, the researcher is confident that the included papers represent current peer-reviewed literature. Also, this review is one of few that have attempted to systematically review and synthesise research concerning constructs acknowledged within the literature to be complex.

Clinical Implications

Review findings highlight a number of clinical implications for MHPs and service managers in relation to supporting staff wellbeing. Findings outline the potential negative impact of attachment insecurity upon MHP wellbeing and, presumably, their overall experience of job satisfaction. Such experiences could have implications upon staff absenteeism (Drake & Yadama, 1996) and staff turnover (Dickinson & Perry, 2002) resulting in financial and strategic implications for mental health services and organisations. Therefore, to reduce the impact of such experiences, the ways employers can support MHPs should be considered. MHPs who are vulnerable to experiencing work related-stress or have

experienced personal trauma should be supported to manage the potential impact of negative personal outcomes in their professional role. Regular individual clinical supervision, peer supervision, and reflective practice could support the development of MHPs' self-awareness. Then, at times when they feel more vulnerable to experiencing negative outcomes, MHPs are more able to take effective action to reduce their vulnerability. Developing a secure supervisory relationship, reflective space in supervision, considering their personal attachment style and understanding how this may impact on their ability to when needed, would increase MHPs' self-awareness and resilience, and reduce vulnerability to negative personal outcomes (Foster, Lichtenberg, & Peyton, 2007). Training (e.g., resilience or mindfulness) to develop MHPs' skills and confidence in independently managing the negative psychological impacts of clinical working more effectively would also be of value. Training could also support MHPs' skill development to compensate for or manage behaviours associated with attachment insecurity (e.g., anxiety, avoidance), further reducing their vulnerability to negative outcomes. Such training would increase MHPs' self-awareness of personal need and increase their consideration of what actions need to be assertively taken to protect both personal and professional wellbeing during times of clinical challenge (Duhoux, Menear, Charron, Lavoie-Tremblay, & Alderson, 2017; Edward, 2005). Changing the culture in health organisations, like the NHS, from being target-driven to becoming more caring and compassionate towards staff and supporting staff wellbeing could further help to deliver the most effective services, in relation to client outcomes and staff retention (Francis, 2013; West & Dawson, 2012).

Future Research

This review is one of few that have attempted to systematically review and synthesise research findings for a number of complex, interrelated constructs. The current state of

existing literature makes understanding these constructs and their impact difficult. This indicates that research needs to be clearer and more consistent in its conceptualisation and measurement of adult attachment and the constructs associated with negative personal outcomes. Higher quality research needs to be conducted in this area to increase the reliability of findings and make their interpretation simpler to enable more effective support for MHPs at risk of developing negative personal outcomes. Although this review identified findings to support the association between attachment insecurity and negative personal outcomes, effect sizes were modest. This suggests that other personal or systemic factors (e.g., support, containment) mediate this relationship. Research should continue to investigate other personal factors such as resilience (Tosone et al., 2015; Tosone et al., 2011), job satisfaction (Burrell et al., 2009) and a sense of coherence (Zerach, 2013), in addition to attachment, to better understand risk factors associated with the development of negative personal outcomes for MHPs. MHPs' ethnicity was not widely reported or considered in relation to findings by authors of studies included in this review. However, future research could explore how this personal factor may impact upon experiences of negative personal outcomes.

Conclusion

Although findings of this review cannot suggest causality, they identify an association between attachment insecurity, particularly for an anxious-ambivalent attachment style, and negative personal outcomes experienced by MHPs. The strength of associations across studies included in this review suggests that although adult attachment is an important factor influencing the experience of negative personal outcomes for MHPs, it is not the only one. Research should continue to investigate the contribution of other factors (i.e., personal or

systemic), in addition to adult attachment, to better understand how to minimise MHP vulnerability to negative personal outcomes in relation to their professional role.

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Chapter 2: Empirical Paper

A Grounded Theory Study of Personal and Systemic Factors that Impact on Clinical Working with Eating Disorders: A Therapist Perspective[2]

Stephanie Keith

[2] This paper has been prepared for submission to the British Journal of Psychology. The journal specifies a word limit of up to 8,000 words exclusive of abstract, references, tables or figures (see Appendix G for author guidelines).

Abstract

Objective: Very little literature has explored eating disorder (ED) therapists' experience of factors that support them in their clinical role. The current study used a grounded theory approach and developed an explanatory theoretical model of how personal and systemic factors enable ED therapists' to work effectively with challenge.

Method: Semi-structured interviews were conducted with twelve ED therapists from child and adolescent mental health services (CAMHS) and adult ED outpatient services regarding their experiences of clinical working with this population.

Results: Participants highlighted the impact of therapist, service-related and unique treatment factors on effective working. Challenge was identified as instrumental in facilitating continuous therapist development and service development through therapist application of strategies, which strengthened effective working with challenge and also their satisfaction in role. Job satisfaction increased therapist motivation and ability to work with challenge. Functional multi-disciplinary team working was identified as crucial to support effective working.

Conclusions: These findings have significant clinical implications for both services and therapists. They highlight the resources needed for therapists to support both their wellbeing and professional development. This provision is essential in maintaining their ability to work safely and effectively with ED clients.

Keywords: eating disorders, therapist, effective, qualitative, challenge

Introduction

In the UK, more than 700,000 people live with an eating disorder (ED) (BEAT, 2015). Within this population, the estimated prevalence is 8% for anorexia nervosa (AN), 45% for bulimia nervosa (BN) and 47% for eating disorder not otherwise specified (EDNOS), inclusive of binge eating disorder (BED) (BEAT, 2015).

Although AN has a lower prevalence rate than other EDs, it has the highest mortality rate (5%) (American Psychological Association, 2013; Hay, Touyz, & Sud, 2012; Strober, 2010,) and a suicide rate three times higher than any other mental health presentation (3-20%) (Nielsen, 2002; Warren, Crowley, Olivardia, & Schoen, 2009). AN is considered a treatment-resistant illness (Hepworth, 1999), because outcomes are poor, due to the treatment aims directly opposing the clients' value to remain low weight (Hay et al., 2012). A meta-analysis by Steinhausen (2002) identified outcomes for AN as 42% full recovery, 33% improvement, 20% chronic ED and 5% death. Associated health complications in AN include cardiovascular, gastrointestinal, endocrine and metabolic difficulties as a consequence of malnourishment (Mehler & Krantz, 2003). In BN the engagement with compensatory behaviours (e.g., purging, laxative abuse) also leads to serious and potentially fatal health complications involving cardiovascular and gastrointestinal systems (National Institute for Health and Care Excellence (NICE), 2017). Herzog et al. (1999) reported a 74% recovery rate for BN in a longitudinal study and reported 99% partial recovery in BN at seven and a half years follow-up.

ED literature predominantly focuses on AN and BN, in relation to intervention studies and treatment outcomes. This is suggestive of the particularly challenging nature of treatment for these presentations in clinical practice. The evidence-base for ED treatment is limited. However, in the context of poor treatment outcomes, it continues to develop. ED services provide community-based treatment to support client maintenance of psychosocial

functioning and independence (NICE, 2017). Thus, the majority of efficacy studies regarding psychological interventions are community-based (Byrne, Fursland, Allen, & Watson, 2011; Knott, Woodward, Hoefkens, & Limbert, 2015; Lock et al., 2010; Waller, 2016). Although psychological interventions are considered crucial in addressing the psychological underpinnings of EDs (NICE, 2017), no definitive psychological treatment approach is empirically supported (Hay et al., 2012). Waller (2016) associated this issue with existing treatment models and other factors precluding treatment delivery.

Client, therapist and service-related factors impact on the successful implementation of psychological interventions for EDs. Complexities relating to ED pathology, client characteristics, therapeutic alliance, treatment evidence-base and risk severity, affects therapists' delivery of psychological interventions (Berkman, Lohr, & Bulik, 2007; Godart et al., 2007; Kaplan & Garfinkel, 1999). These challenges, in addition to experienced negative affect toward clients, are suggested to contribute to burnout in ED clinicians (Kaplan & Garfinkel, 1999; Warren, Schafer, Crowley, & Olivardia, 2013). Therefore, ED therapists experience a number of specific therapeutic challenges in their role. A dearth of literature exists to address the specific ways ED therapists can be supported by both services and themselves to work most effectively with challenge. Literature has, however, recognised these challenges and the paradoxes that exist in ED treatment (Malson & Ussher, 1997). Therapeutic alliance is a robust predictor of therapeutic outcome in ED treatment. However, the psychological rigidity of clients (e.g., resistance, recovery ambivalence) can inhibit the formation and maintenance of a therapeutic alliance (Bruch, 1982; Hay et al., 2012; Reid, Williams, & Burr, 2010). Therefore, therapists must engage creatively with clients using multifaceted interpersonal approaches to facilitate therapeutic change (Gulliksen et al., 2012). Therapeutic difficulties experienced early on in treatment can present professional and personal challenges for therapists. This may lead them to experience countertransferences

and negative attitudes toward their clients (Crisafulli, Von Holle, & Bulik, 2008; Satir, Thompson-Brenner, Boisseau, & Crisafulli, 2009), which further impact on therapeutic engagement. Therefore, maintaining a boundaried approach to clinical work with EDs (e.g., in session, risk management) supports therapists to manage their emotions including anxiety, frustration, and hopelessness (Snell, Crowe, & Jordan, 2010; Thompson-Brenner, Satir, Franko, & Herzog, 2012). Service-related factors including limited resources, pressures, and organisational demands have been identified to also impact upon effective working for ED clinicians (Davey, Arcelus, & Munir, 2014).

Thompson-Brenner (2013) highlighted a common misconception of ED clinical work as being unpleasant and discussed the high levels of job satisfaction experienced by ED therapists compared with non-specialists. When investigating clinicians' experiences of working with EDs, Warren et al. (2013) found, compared with non-specialists, despite high levels of emotional exhaustion, higher levels of reported personal accomplishment. This was hypothesised as protective of burnout. Few studies have considered the rewards experienced by therapists as a way to understand the factors that enhance their continuation in the field. Professional growth and personal development are considered fundamental for the maintenance of professional competence for psychological therapists (Rønnestad & Skovholt, 2003). Some studies have reported that enhancing therapeutic engagement skills to enable the development of rapport and trust with ED clients, despite interpersonal challenges, as highly valued by therapists (Davey et al., 2014; Warren, Schafer, Crowley, & Olivardia, 2012). Therefore, skill development in the delivery of long-term, intensive therapeutic interventions and risk management, through clinical practice and continued professional development (CPD) opportunities, could be rewarding for therapists (Gulliksen et al., 2012; Rønnestad & Skovholt, 2003).

Research has investigated effective ways of working for ED therapists to preserve both their personal and professional wellbeing. Few studies have reported the role of services in supporting therapists. Good quality, therapist-centered supervision (Glass, 1986) and personal therapy (Wheeler, 1991) enhances therapists' understanding of themselves, a process which leads to therapists' emotional containment. Self-awareness, the ability to tolerate uncertainty and reflection upon emotional reactions towards clients within supervision or reflective practice are highlighted as essential to therapists' personal well-being (Glass, 1986; Nutt-Williams & Fauth, 2005; Turner, Tatham, Lant, Mountford, & Waller, 2014). Engagement with self-care activities, as a means of self-nurturing, supports the maintenance of a work-life balance and increases opportunity for positive engagement with ED clients (Warren et al., 2012; Warren et al., 2013). Multi-disciplinary team (MDT) working is of particular importance to effective ED treatment (NICE, 2017). However, therapist challenges also relate to the service and team they work alongside. Given the importance of CPD, services should provide adequate resources to enable therapist development in working as part of a team. Effective team working in psychological services requires leadership to facilitate clarity of professional roles, clear clinical procedures and opportunity for communication (British Psychological Society (BPS), 2007).

A small number of qualitative studies have investigated the experiences of ED clinicians, including therapists. Walker and Lloyd (2011), on interviewing non-specialist ED healthcare workers, identified a number of barriers preventing effective working. These included professional attitudes (e.g., EDs as illogical, hard to understand), countertransferences (e.g., frustration, self-evaluation) and limited service provision (e.g., training, supervision). Similarly, in considering client factors, Jarman, Smith and Walsh's (1997) study, interviewing community-based MDT clinicians working with children, identified rigidity and control in AN as particularly challenging. Qualitative literature has

also explored the impact of service-related factors on treatment. Davey et al. (2014) interviewed healthcare staff working with adult inpatient clients and identified the negative impact of organisational demands on job satisfaction, leading to a reduced ability to work effectively. Reid et al. (2010) investigated MDT clinicians' experience of working in both adult National Health Service (NHS) outpatient and inpatient service settings. Reported challenges related to treatment, inadequate service resources, in addition to client challenges itself. ED clinicians, in Warren et al.'s (2009) mixed methods study, outlined supervision, team working and looking after oneself as most important to support effective working with EDs. Research clearly highlights the challenges to effective working in this field and suggests some ways therapists can be supported to work with challenge.

The Current Study

Few studies have explored how ED psychological therapists are supported by services to work effectively with challenges in their role and even fewer have investigated therapist rewards. This suggests that this particular area of research requires further investigation. The current study aimed to expand current literature by using a grounded theory approach. It aimed to develop an explanatory theoretical model of the personal and systemic factors that enable effective working with challenge for ED therapists in their clinical role. It aimed to develop this model to better understand the processes involved in therapists' experience of rewards and challenges, personal reactions and the personal and systemic factors supporting and hindering them in relation to clinical working.

Method

A modified version of grounded theory (Charmaz, 2014) was used to go beyond the data to develop a theoretical understanding of the social processes reported by participants. This approach holds a 'constructivist epistemological' position, which regards emerging theory, not as an objective truth, but representative of the subjective understandings, experiences and shared meaning of both researchers and participants. Maintaining a 'symbolic interactionism perspective', allows researchers to view individual experiences as shaped by external, social processes (Charmaz, 1983). A double hermeneutic approach to analysis prioritises flexibility in both data collection and analysis (Charmaz, 1991, 2014). This methodological approach was felt most appropriate to meet a number of study objectives. It allowed the process of effective working to be understood and demonstrated through the development of an explanatory theoretical model. Another study objective was to capture the lived experience of ED therapists and a grounded theory approach allowed for the recruitment of a heterogeneous participant sample and the exploration of similarities and differences of both child and adolescent mental health services (CAMHS) and adult therapists.

Expert by Experience Consultation

Both Liverpool Expert by Experience group members and four ED therapists, deemed experts by experience (EbEs), were consulted early on in research planning. Feedback from these consultations led to the adaptation of a more amenable recruitment approach for participants and more relevant phrasing of some interview questions. Consultation with EbEs throughout the later stages of analysis, post interview eight and on interview completion, supported the validation, development, and conceptualisation of the theory.

Ethics

The University of Liverpool Health and Life Sciences Research Ethics Committee and research and development department at the NHS recruitment site approved this study. Once approvals were received by the Clinical Research Governance Team, sponsorship was granted by The University of Liverpool (see Appendix H).

Recruitment

Participants were recruited from one NHS trust, across four CAMHS and four adult mental health ED services, located in England. At the time of recruitment, CAMHS had been commissioned to treat EDs using a new service model and had been doing so for the past 12 months. CAMHS participants were based within generic CAMHS teams. Prior to recruitment, service leads were contacted to discuss research aims and confirm service involvement. Service leads provided contact details to the researcher for psychological therapists who had agreed to be contacted. Therapists were contacted by e-mail and telephone and were asked to re-confirm their participation interest upon reading the participation information sheet they received via e-mail (see Appendix I). Once an expression of interest was confirmed, the researcher then collected information from participants to screen for eligibility using inclusion and exclusion criteria. Eligible participants were asked to confirm either a convenient interview date or date for future contact to allow opportunity for theoretical sampling. All contacted therapists expressed a participation interest. Participants were reimbursed with a £20 voucher.

Participants and Sampling

Twelve therapists (eleven women, one man) with experience of working with EDs ranging from 11 months to 11 years participated. All participants worked exclusively with

ED clients in either CAMHS or adult ED outpatient services. Participant demographic information is presented in Table 1. Interviews took place between February-November 2017.

Participants were qualified psychological therapists, actively working with ED clients in outpatient settings, with a minimum of 6 months experience working therapeutically with EDs. The term qualified therapist was defined as a professional working in a therapeutic role delivering psychological therapy with; either a formal therapeutic qualification or a core Health and Care Professionals Council (HCPC) recognised qualification, short therapeutic training course(s) attendance and working under the clinical supervision. EDs are predominantly treated within community-based settings (NICE, 2017). Thus, this was the rationale for recruiting participants from outpatient services. Participants had the opportunity to reflect on experience of inpatient working. Participants were required to have at least 6 months therapeutic experience to have adequate experience to reflect upon during interviews. Participants working within a dual role (e.g., service lead and ED therapist) were also included. Two potential participants were excluded, as they were not working with ED clients at the time of recruitment.

Convenience sampling was applied to the first four participants. An a priori decision was made to recruit both CAMHS and adult therapists to develop theory based on the experiences of therapists working with a range of EDs. Participants were subsequently recruited via theoretical sampling, informed by analysis, based on information gathered during initial participant contact, to explore the relationships between narratives and participants' service type, gender, and role. To see how this was operationalised see Figure 1, below.

Table 1
Participant Demographic Information

Participant	Gender	Therapist experience (years)	ED experience (years)	Service
1	Woman	3	3	Adult
2	Woman	18	2.5	Adult
3	Woman	17	10	CAMHS
4	Woman	10	11 months	CAMHS
5	Woman	7	5.5	Adult
6	Woman	15	1	CAMHS
7	Woman	7	3	CAMHS
8	Woman	3	1	CAMHS
9	Man	11	11	Adult
10	Woman	4	2.5	Adult
11	Woman	4	3	CAMHS
12	Woman	10	10	Adult

Note. Further demographic information is available upon request.

Interviews

Interviews were conducted by the researcher at participants' workplaces, which were all secure NHS outpatient services. Participants were e-mailed a participant information sheet (see Appendix I) to read prior to the commencement of interviews. Before signing a consent form (see Appendix J) participants were given another opportunity to read the information sheet and ask questions. Prior to commencement of interviews, interview and client confidentiality and the right to withdraw from the study were discussed with participants.

Each participant was interviewed once using a semi-structured interview guide (see Appendix K) to explore their experiences as an ED therapist, which included the following topic areas: demographics (e.g., 'What is your therapeutic orientation?'), EDs (e.g., 'What are the challenges you face in your role?'), service structure (e.g., 'How do you experience pressure in your role in regards to NHS demands?'), team support (e.g., 'How do you experience working within your current team?), clients (e.g., 'Tell me how you feel about working with risk presenting in EDs?) and therapist factors (e.g., 'Can you tell me about any feelings that arise for you when working with this client group?'). Interviews lasted between

49-73 minutes and were recorded with an electronic voice recorder. The researcher conducted all interviews and adopted a curious approach. This allowed interviews to remain flexible and adapt to participant responses, maintaining a phenomenological position to probe areas of interest (Smith, 1995). The interview guide evolved and became more refined as interviews were completed, to allow for the exploration of emerging themes. It was adapted after interviews six and 10 (see Appendix K).

Reflexivity

In the early stages of the research process, the researcher wrote a reflexive statement based on their expectations and thoughts. This transparency was important to ensure that they did not impact upon data collection or analysis (see Appendix L).

Quality Assurance

A number of quality assurance procedures were undertaken throughout the research process to ensure consistent reflexivity and transparent working (Walsh & Downe, 2006). Regular supervision and memo writing allowed for a reflexive approach. During interviews, the researcher held a non-assumptive, curious stance. The interview approach was refined through supervision, on inspecting interview transcripts, memo writing, and consultation with a grounded theory peer supervision group. Supervisors completed validation checks by independently reviewing interview transcript coding at various stages of analysis. Feedback was essential to the refinement of these two processes. Line-by-line coding allowed analysis to remain close to the data and incorporate participants' language and meaning into the coding process. EbEs participated in validation checks during theory development.

Analysis

In line with applying a modified approach to grounded theory (Charmaz, 1991, 2014), each transcript was analysed using a method of applying line-by-line, focused and theoretical coding as outlined by Bennett and Vidal-Hall (2000). Analysis using these coding systems was undertaken using a constant comparison approach supported by memo writing, reflective diary writing, coding maps, and supervision to refine analytical thinking (see Appendix M). Supervisors conducted validation checks. Interviews were transcribed and coded prior to subsequent interviews. For each interview, reflective summaries containing participant narratives, interview impressions, emerging theory, interview critique and a diagrammatic summary were recorded (see Appendix N).

A systematic approach to analysis was undertaken using an electronic software package (Excel) (see Appendix O). The researcher transcribed the first three interviews to become fully immersed in the data and closer to participant narratives. Prior to initial coding, each transcript was read in full and re-read during the process of line-by-line coding. Codes were reviewed to consider their potential for abstraction for focused or theoretical codes. Following interview five, line-by-line codes were retrospectively and prospectively synthesised into emerging categories for all transcripts. This coding process resulted in a total of 56 focused codes (e.g., countertransference, therapeutic challenge, self-awareness). For an illustration of the coding process see Appendix P. The adaptation of interview guides and theoretical sampling methods were informed by focused codes in an iterative process to inform theory development (see Figure 1). Coding throughout was reflexive whereby transcripts were re-coded as new codes emerged. Focused codes were mapped for both individual and combined transcripts (see Appendix Q). Theoretical codes, developed through the grouping of the most prominent and relevant focused codes, for the current study (see Appendix Q), formed six conceptual, higher-level categories: job satisfaction, challenge,

therapist strategies, unique treatment factors, service-related factors and therapist factors. During the theoretical coding process transcripts were re-read and focused codes were further inspected for internal themes to fully synthesise the data and raise it to an abstract level of analysis. Theoretical coding decisions were supported by memo writing to inform theory development. As no new focused codes emerged after interview 10, the last two interviews were used to check and refine theoretical thinking. As theoretical saturation was reached at interview twelve recruitment was closed.

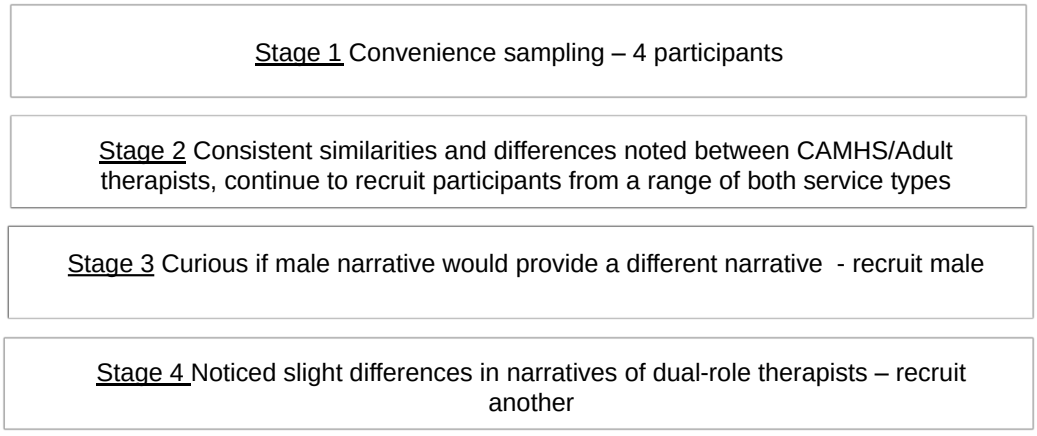

*Figure 1***.** Theoretical sampling process

Results

Figure 2 illustrates the explanatory theoretical model of findings, highlighting significant personal and systemic factors that influence the process of effective working for ED therapists. The model is formed by six main categories: job satisfaction, challenge, therapist strategies, unique treatment factors, service-related factors, and therapist factors, the majority of which share a bi-directional relationship with at least one other category. The model has three peripheral categories: therapist factors, service-related factors and unique treatment factors. These categories each link into three internal categories: job satisfaction, challenge and therapist strategies. Service-related factors has a bi-directional relationship with each internal category. Therapist factors, at the top of the model, has a bi-directional relationship with job satisfaction. Unique treatment factors has a linear relationship with each internal category. Both job satisfaction and challenge and challenge and therapist strategies share a bi-directional relationship. Therapist strategies has internal bi-directional relationships with its sub-categories: professional development, personal development, and service contribution. Therapist strategies, through a linear relationship, links to job satisfaction at the top of the model.

In summary, the process of therapist effective working, experienced as the movement through each internal category, is described below beginning with therapist factors. Each category is based on focused codes most pertinent to the model and is supported by participant quotes throughout.

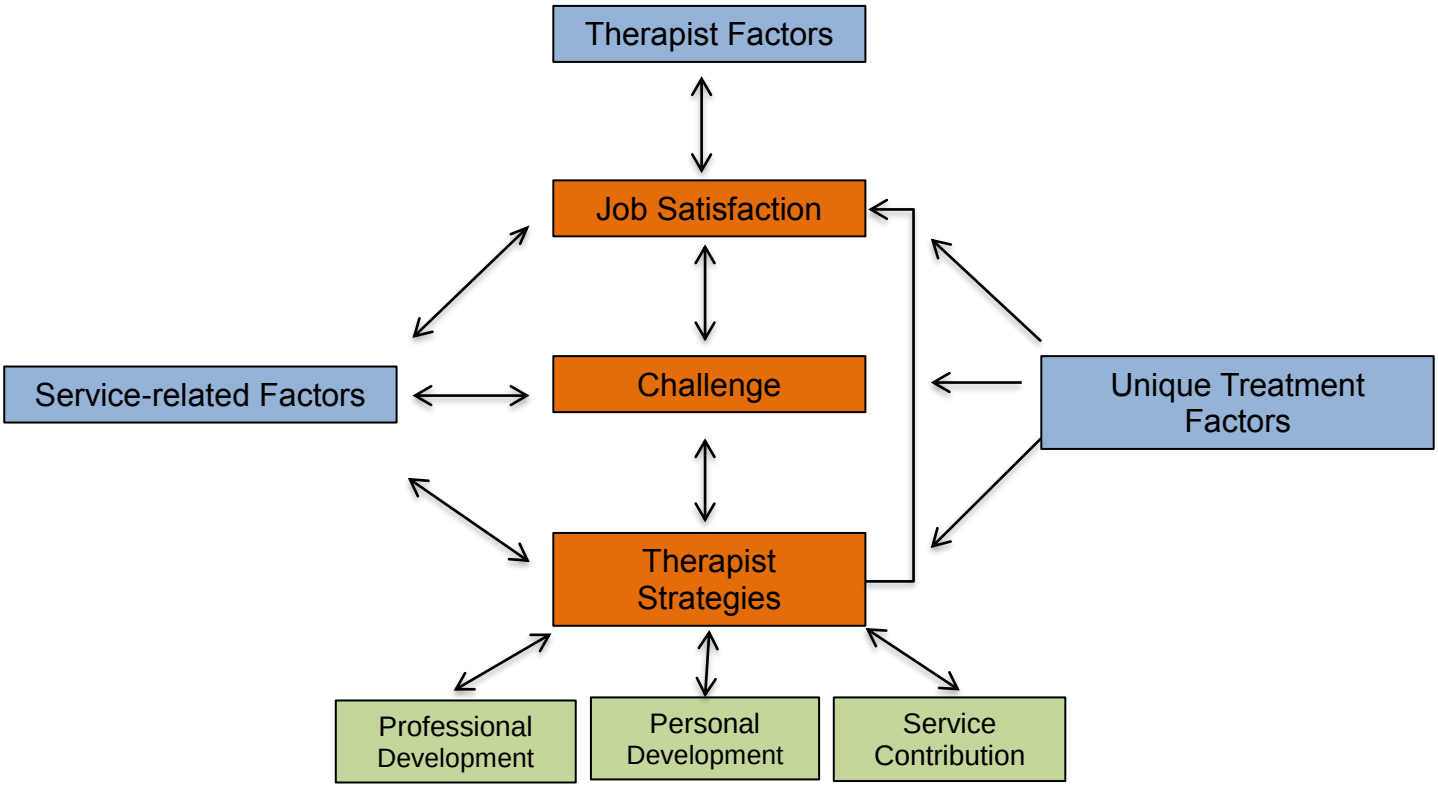

Figure 2. Grounded theory model based on ED therapists' experience of factors supporting effective working with challenge

Therapist Factors

Therapist factors describe therapists' personal contributions to their role, which continually support them to remain interested and motivated to work in this field. A number of personal attributes (e.g., striving to perform well, working conscientiously and empathically with clients and colleagues) typically associated with caring professionals, were described:

> Seeing where it can take people is so awful… people are cold all of the time, so they just become so impoverished…to see all of this potential quite literally disappearing it's heart breaking... (P2)

Such attributes enabled therapists to experience personal achievement working with challenge, leading to job satisfaction and their continued working in the field. ED clients

appear to offer therapists an opportunity to be challenged, develop and have their personal needs met concerning feeling effective, capable and 'special' in their ability to work with complexity.

Professional attributes (e.g., experience, therapeutic skill, job role) also influenced how therapists experienced their role. Therapist confidence in working with therapeutic challenge was supported by ED experience and therapeutic training. Less experienced therapists expressed more interest in developing their therapeutic skills to get their therapeutic approach 'right'.

Service-related Factors

All therapists discussed how fundamental service-related factors were in influencing their ability to work both personally and professionally with challenge. These factors impacted directly upon their ability to function and thrive in their role and experience job satisfaction. Conversely, therapists, through experiencing job satisfaction and confidence in their ability to work with challenge, directly impacted on the service in which they worked, through service development and maintaining team functioning (see Therapist Strategies).

Factors supporting clinical working included service stability, team functioning and cohesion, supervision, reflective space, peer support, training, clear service protocols and supportive leadership to manage commissioning pressures. Such factors enabled therapists to feel contained and confident in their role. The absence of accessible and adequate service-related support led therapists to feel overwhelmed and de-skilled, reducing job satisfaction. Service leads, more aware of wider systemic pressures, described being more mindful to support colleagues during times of pressure. Some CAMHS therapists, working with a new service model, noted a lack of the above factors. They reported feeling disconnected and rejected in working at a distance from the specialist ED service and other ED colleagues.

They described having to resourcefully seek support from other CAMHS teams. Adult ED therapists in more established services with clear leadership and large staff teams did not discuss difficulties in accessing support.

Unique Treatment Factors

Therapists regarded this clinical field as specialist and challenging, due to the combination of factors working against successful treatment, including client process factors (e.g., ambivalence, poor engagement, psychological inflexibility) and dual-risk management (i.e., medical and psychological) requiring MDT working. These factors exist in the context of an insufficient treatment evidence-base, poor outcomes, and high mortality rates:

> …Eating disorders themselves aren't really fully properly understood yet…the presentations…and the reasons for their behaviours are so different that one size just doesn't fit all. It genuinely doesn't. (P10)

The paradoxical view of ED therapists as 'specialists', also believed by non-specialist colleagues, was held by therapists alongside an awareness of an ability to feel quickly de-skilled. The dilemmas and challenges of working therapeutically in this field influence the effective strategies undertaken by therapists, consequently contributing to their development. The majority of therapists reported experiencing personal reward and job satisfaction in their role.

Job Satisfaction

Therapists described factors influencing job satisfaction, including experiencing reward, client outcomes, self-affirmation, team cohesion and service pressures. Therapists

experienced job satisfaction when their clinical work corresponded with their personal values:

> Actually knowing that…you're improving somebody's mood or giving them more opportunities and… belief in themselves…(P7)

Work was experienced as rewarding particularly when positive therapeutic outcomes were achieved as this demonstrated, to themselves and others, their aptitude as a therapist. Although achieving client recovery, particularly for AN, was acknowledged to be difficult, and not always the primary focus of psychological interventions, they described it as the ultimate reward. For example:

> Researcher: So how does that impact on you, knowing that you have that ability to go on that journey with the family?
> Participant: It's really rewarding and it…gives you that bubbly feeling inside…you can go home and [think] you've actually done a good job. (P8)

Despite numerous clinical challenges, therapists experienced achievement and recognised the meaningfulness of their work through appreciating change, no matter how small:

> Change is…really, really slow and even that much change [*demonstrates small distance between fingers]* is phenomenal. (P1)

This was achieved through adapting to the concept of 'good enough', which enables therapists to be realistic and accept which therapeutic outcomes are achievable. 'Good

enough' supported therapists' job satisfaction by allowing them to re-frame clinical challenges and feel competent and effective as a clinician:

> Self-care is…staying okay in the field is about coming to terms with things mentally so it's…knowing that I'm doing a good enough job. It's keeping in touch with other people enough that I know the problems that I'm having are the same…(P9)

Job satisfaction was also maintained by working with a caseload of varied complexity and presentations as this increased opportunity to achieve positive clinical outcomes and reduce burnout:

> If you've got a balance of your caseload and people who are…being successful…they're progressing, and they're restoring their health and the families are on board…job satisfaction can be really high. (P11)

Positive client outcomes were self-affirming for therapists. They increased their confidence in their ability to work within a specialist clinical field that many professionals fear and avoid:

> So…it's really rewarding and it's gratifying and it gives that, sort of, sense of…this is helpful…this is worth it. (P2)

Teamwork contributed to increased job satisfaction. Working as part of a cohesive team with positive working relationships provided containment and support for therapists and vice

versa for teams. A common example of how teams demonstrate cohesion was through using humour:

> It just brings light to really difficult times…you come out of a session and you've been dealing with some really dark, difficult stuff and that…sense of humour and that banter in the office I think…is like peer support. (P8)

Positive team working was more common when there was a nurturing ethos. This enabled therapists to feel a sense of belonging and to be valued and cared for by colleagues:

> I feel like I'm recognised as a valued member of the team…we each care about the individual members in the team. (P5)

Poorer job satisfaction was associated with stuckness relating to clinical challenge:

> It only takes kind of one really stuck anorexic on your caseload and that can bring out all the aspects of the job that you don't like…I've certainly said a number of times before give me a sparky bulimic any day. (P5)

Experiencing a lack of adequate support to overcome role-associated challenges predominantly impacted upon job satisfaction, leaving therapists feeling isolated and overwhelmed:

> My colleague's gone off to do training, so…I have been left on me own…pretty crap really…lots of pressure, no support. (P3)

Job satisfaction, both with respect to clients and team working, varied. Therapists suggested that this fluctuated, especially in relation to service-related pressures and challenges. For example:

> …I enjoy my job, I don't enjoy the environment of the NHS…we're being carved up all over the place and it doesn't feel like it's particularly secure… but actually in terms of me working as part of our team, me sat in a room with clients, I'm getting quite a lot of satisfaction out of that… (P5)

Job satisfaction derived from feeling accomplished in working with clinical and therapeutic challenges effectively. Therapists developed to be motivated, interested and able to continue working in this field, enhancing both personal and professional attributes:

> It is such a hard area to make long-term change in, when you do, it's such a fantastic feeling. (P7)

Challenge

Most therapists experienced EDs as more clinically challenging compared to other areas of mental health. This reinforced the perception of EDs as specialist and complex:

> I suppose it does come with extra challenges…I think because it's a… mental health condition but there's significant physical health risks that can occur as well and it's balancing those two. (P10)

Positive and negative challenges were discussed in relation to both service-related and unique ED treatment factors. Both types of challenge were associated with therapists' continuous development, contributing to job satisfaction and therapists' interest in their role. Positive challenge was directly associated with therapists' ability to rise to the challenge of therapeutic work and their ability to maintain hope through uncertain treatment journeys. Therapists experienced personal accomplishment in being able to work successfully with complexity:

> It's so nice to see the journey. And I think it's so much more rewarding…because you take somebody from the place where "oh my goodness they could die" to "they've got a life back". (P8)

The management of psychological and medical risk was described as complex and uncontaining, particularly for AN and BN. Therapists experienced this blurring of their professional role as de-skilling and anxiety provoking:

> I always have that fear…it's okay having my risk assessments up to date and all of that but…this is life and death with some of our clients. (P12)

Therapists were aware that they are not alone in experiencing difficulties in managing this dual-risk:

> Even GPs are fearful of it and they're physically trained. (P6)

CAMHS therapists, with clients more likely to be physically compromised by medical risk, were particularly aware of their consequences:

> Knowing the stats around…the deaths…the percentage of it that's due to physical health and the percentage that is due to suicide, that's quite high. (P11)

CAMHS therapists, compared to adult therapists, highlighted more issues regarding a lack of clear procedures to manage medical risk:

> I hope in the longer term future there will be that…service level agreement with our paediatricians so that we can access them, not just on goodwill. (P8)

Interestingly, some therapists who had completed nurse training felt that their medical knowledge exacerbated their anxiety in knowing 'too much':

> Sometimes they walk in and their pallor is terrible…they look really poorly, they can hardly stand up…that makes me panicky and I think that is keying into…being a general nurse. (P3)

Challenging client process issues (see Unique Treatment Factors) were noted to impact on therapeutic alliance, particularly for AN. This contributed to therapist *stuckness* in being unable to make treatment progress:

> With eating disorders there's a battle. They are digging their heels in, hanging on by their fingers nails. (P5)

This was experienced as both emotionally and professionally challenging, requiring the utilisation of therapeutic skills and perseverance to develop and maintain a therapeutic relationship:

> Trying to hold optimism and advocate change whilst still trying to engage a client and trying to…nudge them along to change when…you're being met with a lot of resistance…that can really take its toll. (P5)

Therapists acknowledged a lack of strong evidence-base for treatment. Issues with the successful application of existing evidence-based treatment protocols in the presence of process issues were described as de-skilling. Therapist *stuckness* increased feelings of ineffectiveness and hopelessness in being unable to achieve positive outcomes, behavioural or cognitive, for clients:

> That feeling of helplessness sometimes…that you can't make someone eat. (P2)

Team functioning was described as being reduced by service pressures including limited resources, client complexity, and insufficient staffing. This highlighted its importance in supporting therapists and the role of therapists to enhance team functioning. When reflecting on learning points from clinical experience, participant 1 explained:

> To know about the [team] dynamic and what gets played out…in the room and those [team] meetings. To have a bit more of an idea about how difficult this client group is to treat, at times, that actually…you need to stay as a team.

Reduced opportunity for communication (e.g., shared thinking, reflection) within MDT meetings, was reported as problematic as therapists felt unable to connect with colleagues to process clinical challenges:

> Time is the big factor…in an ideal world it would be great to sit and have reflective practice, but we don't have the time…(P12)

All therapists discussed client fragility and vulnerability. They described experiencing strong countertransferences in relation to this:

> A few times I've said…"Oh I just want to put them in my pocket and take them home and look after them". (P10)

CAMHS therapists communicated a sense of responsibility for the recovery of their younger, more vulnerable clients, despite also working with parents to hold this:

> Researcher: So…what do you find to be the most rewarding part of your role?
> Participant: I support people getting…better. Feeling that I am responsible for that...although they wouldn't say so. (P3)

Reviewing and sharing responsibility for recovery with adult clients with chronic presentations protected therapist wellbeing and reduced feelings of sole responsibility for clinical outcomes:

> …There's the working out how you deal with the way that some people are very stuck and that maybe some people don't change and that it's trying to work out how much responsibility you feel you have in [someone's] recovery or not. (P9)

Senior therapists, particularly service leads, reported a greater sense of responsibility to protect colleagues:

> Participant: You have to do quite a lot…to make people feel valued and listen to their opinions.
>
> Researcher: So…as a manager…if something happens within the team…if there is a rupture…
>
> Participant: Yeah. Then I can make sure that everybody is ok. (P1)

To work effectively with challenge, therapists described utilising a number of strategies.

Therapist Strategies

Strategies support therapists to work effectively with unique and continual challenges. In a reciprocal process, the implementation of strategies enables continuous learning and therapist development, which informs strategy selection. Therapist development occurs both professionally and personally. It is also experienced through service contribution whereby therapists contribute to and gain from service development. Development is supported by service-related and therapist factors, working to strengthen professional identity. Development was recognised as an adaptive response to challenge:

> It was useful having my appraisal last week because I thought "actually yeah we have come a long way" but…on day to day basis you think "oh god. Are we actually making any [difference]?". (P6)

Supervision contributed significantly to development. Formal supervision enabled thinking around clinical complexity and processing of the emotional impact of sessions to inform future working:

> Supervision again is useful, and…having a little bit of space in the day…to recognise what's gone on and how you're feeling and, sit with it for a bit. (P10)

Informal supervision with colleagues was especially valued:

> Quite often if I've kind of been like a headless chicken thinking "oh my goodness I've got a crisis I don't know what to do" I know I can knock on any door or I can pick up the phone and ring…(P8)

Professional development. Professional development was described broadly as enhancement of therapeutic skill and approach. Specifically, the development of engagement skills, when facing client ambivalence, enhanced therapeutic alliance and engagement with psychological therapy:

> Researcher: What have you learnt the most…working with this particular client group?

> Participant: For myself as a therapist I've probably learnt how to engage somebody that really doesn't want to…it really enhances that skill. (P3)

Eating-disorder specific training also contributed to skill development. When experiencing minimal therapeutic change, additional therapeutic skills enhanced therapists' sense of effectiveness:

> I love to have a tool bag that I can…keep throwing things out as opposed to it being very [limited]…and I think that's why I've gone from having the CBT skills, adding the DBT skills…(P8)

Working with generally, poor outcomes and a limited treatment evidence-base was recognised as an opportunity for development by some therapists. Clients enabled a sense of therapeutic autonomy for therapists to create individualised interventions with the hope of increased effectiveness:

> In bulimia…the evidence-base is still stronger for a…more slightly manualised guided self-help type approach, whereas anorexia that isn't there so there's more freedom to…formulate and plan a…course of treatment that really feels like it fits. (P9)

An ability to work with the prospect of poor client outcomes, particularly in adult clients, was achieved through holding a realistic perspective about the control therapists had over recovery (see Challenge: responsibility). This resilient perspective allowed therapists to hold

realistic expectations about achievable outcomes:

> I can be the best therapist in the world and if someone is completely stuck and they're not ready to change then I think…it's not going to happen so I'm realistic in that. (P9)

Maintaining professional boundaries was regarded as important in upholding role identity. Therapists discussed the importance of trained medics managing medical risk:

> I don't think it's appropriate for me to be giving out too much advice… because I am not qualified enough…it is my responsibility…to ensure that I'm assessing for any medical risk and passing the appropriate information on, requesting…consultations from those that are qualified. (P7)

Robust risk management was achieved through clarity of medical risk management responsibilities. This allowed therapists to work within their level of competency to manage psychological risk. Sharing responsibility with parents and carers, when required, also supported therapists' risk management approach.

Maintaining role boundaries, despite the emotional pull of vulnerable clients, was recognised as important for clients and also team functioning, to avoid splitting:

> You might be really trying to hold boundaries but then someone else will jump in and rescue, and offer the appointment… you can't keep rescuing people. (P12)

Personal development. Working with this client group facilitated therapists' personal development, both within and outside of the therapeutic setting. This was achieved through

increased self-awareness and acknowledgement of the impact of the clinical work. Professional development, allowing therapists to be skilful in working with challenge, led directly to a shift in their perspective of their ability to tolerate clinical uncertainty:

> Professional development has happened by the progression from avoidance to engaging more and taking on high-risk clients. So, the…outcome of that is that that's helped to build my confidence... (P12)

Confidence in working effectively enabled therapists to feel accomplished in their ability to work competently with clients (see Job Satisfaction: good enough). Effective working was not defined by successful outcomes:

> Even if you don't work successfully with them…knowing that I've done the best level of care and that you've provided the structure…negotiated all the psychiatry appointments and helped them get even to the point of referral I think that's rewarding in itself... (P11)

Learning to work with and process strong emotions in session increased therapists' understanding and appreciation of client vulnerability:

> Emotionally…I really understand how trapped people get… how helpless everyone else gets and how increasingly helpless and increasingly trapped. (P2)

A developing understanding of social influences contributing to the development and maintenance of EDs also led to shifts in their understanding of clients. When reflecting on learning from their role, participant 10 explained:

> When somebody has a difficult relationship with food that impacts so many people around them, including the therapist…family, friends, the school…that it can be just so poorly understood by people...well-meaning people can try and help and have such a negative impact on it without intending to.

The blurring between professional and personal life in being unable to 'switch off' from eating habits and body image issues of others was challenging for some therapists. The occupational hazard of therapist hypervigilance to protect loved ones impacted on others:

> I think I'm saying more things to my [daughter] than I would be saying if I didn't work in eating disorders…like our bodies are great because of what they allow us to do and…just really positive things about her tummy and her legs… (P5)

This knowledge increased therapists' awareness of their personal health and self-care they engaged with:

> I think just it's…made me more mindful about getting that balance right between enjoying food and exercise and looking after my body…(P4)

Self-care was regarded as important for safe and effective working with EDs to maintain a work-life balance and manage stress (e.g., part-time working, family, hobbies):

> Sometimes when you feel like the four walls are closing in, it's easy to want to retreat and actually making sure that I am still making use of those relationships and social interactions. (P5)

Supporting mental wellbeing in work was regarded as an important form of self-care (see Job Satisfaction: good enough). Seeking support from colleagues was noted as a way to manage this:

> If we've had a difficult client and there's…another practitioner next to you…it's really handy to be able to say "oh my god…I've just had a horrendous session". (P5)

One CAMHS therapist described her experience of becoming overwhelmed as a consequence of lone working in a busy service. Burnout resulted as consequence of being unable to gain adequate support:

> I'd managed to…get the backlog out of the way. I made myself ill in the process… so then I started to think " right, how am I going to get myself back on my feet?"(P8)

Service contribution. Therapists described using a number of strategies that both enhanced service development and their teams' functioning. Therapists valued working with professional ED networks. Accessible and robust MDT working contained therapists through communication and allowed opportunities for a perceived shared responsibility, particularly around risk. This alleviated pressure on them:

> As much as I have said that our team meetings are difficult…anybody that is risky is discussed in that team meeting and it is minuted. So, although you may see them individually, you know that you don't individually carry that risk...you've discussed it with everybody else…(P1)

Although time for MDT reflective space was limited, this, in addition to supervision, enabled shared thinking to support therapists to process and problem-solve clinical challenges:

> We do some case discussion within MDT. So through rolling reviews we tend to say where we're up to and if we're stuck with something or we might have used that as a…"where are we going with this?". (P5)

CAMHS therapists receiving a lack of adequate support, as outlined above, highlighted the importance of team working. Despite support from the CAMHS team they were based within, the absence of consistent support from the wider ED network left them feeling anxious and isolated:

> I don't think that as yet has been working as well as I hoped. It hasn't felt as robust and coherent…(P4)

Pro-active communication with colleagues allowed therapists to get their professional and personal needs met during difficult times. Some therapists were required to assert themselves more during times where team functioning was strained:

> If I'm really struggling then…I've got a big mouth, I can shout and say "I'm really struggling, you need to help me now". (P8)

As discussed above regarding supervision, consulting with colleagues enabled team and therapist functioning. Being listened to allowed therapists to feel valued and held in mind:

> We had one [consultant] that was quite analytical and reflective…that was really good. And it was interesting because it was a time that the team really felt valued because our, we were heard, and our word was counted. (P12)

Overwhelmingly, support from colleagues was valued. This enabled their development through shared thinking, sharing of clinical knowledge and peer support, particularly concerning emotional wellbeing (see Personal Development). Colleague support was consistent, regardless of challenging team dynamics. A sense of camaraderie and nurturing team ethos was noted as essential for therapists in managing challenge (see Job Satisfaction).

Service development, achieved through liaising and building relationships with other professionals and agencies that work with ED clients, was recognised as contributing to effective working. CAMHS therapists, predominantly, described working to improve working practices (e.g., referral criteria, risk pathways, connecting with medics) through communication and networking with relevant professionals:

> Building relationships up with the paediatricians. GPs…going into schools and working with them…as well as the executive counselling services that we're referring in … (P8)

Therapist strategies, through enabling effective working with challenge, allow therapists to experience job satisfaction in relation to personal accomplishment and reward.

Model Summary

Therapist factors continually influence therapist experience of their role and job satisfaction and enable therapists to contribute toward and continue working in the field of eating disorders. Service-related factors significantly influence therapist effective working through impacting on job satisfaction, challenge and strategy selection. Unique treatment factors combine to make ED treatment both uniquely rewarding and challenging for therapists. These factors ensure that therapists work flexibly with challenge through applying strategies to enable effective working. Therapist strategies contribute to job satisfaction, which enables therapists to remain motivated in their role and strengthens existing therapist factors. Therapists' experience of job satisfaction enables them to impact upon both service and team functioning. Challenges experienced as positive and negative, contribute to job satisfaction and also therapists' application of strategies, which must be utilised to overcome experienced clinical challenges. The accumulation and increased incidence of challenge within a service also impacts upon how the service and team function to overcome them. Therapist strategies implemented to work with challenge leads to the professional and personal development of the therapist as well as contributing to the service and team development. This is a reciprocal process that enables continuous learning. Strategy selection is informed by therapist development and also the availability of service-related factors, presenting challenges and the presence of unique treatment factors. Therapist strategies allow therapists to work effectively with challenge and also strengthen service development. Effective working and development lead back to job satisfaction and so the cycle continues.

Discussion

This study explored twelve ED therapists' experience of working with challenge and reward in their role. It extended existing literature through developing a theoretical model to explain the personal and systemic factors supporting ED therapists to work effectively with challenge in their clinical role, in outpatient settings.

Findings outline three categories of personal and systemic factors that impact on clinical working with EDs. The significance of job satisfaction in this model, enhanced by professional attributes including ED experience and professional training, is supported by existing literature (Walker & Lloyd, 2011; Warren et al., 2013). This study also identified the importance of therapists' personal attributes in enabling reward and personal accomplishment, contributing to job satisfaction, which has been less widely reported in the literature. Interestingly, therapists regarded this clinical field as specialist due to unique treatment factors. Therapists described these factors, although common to other mental health populations, as combining in EDs to work against successful treatment. Unique treatment factors including client process factors, risk, poor evidence-base and challenges associated with them are supported by existing literature (Hay et al., 2012; Malson & Ussher, 1997; Wheeler, 1991). Research also supports findings of this study regarding the importance of supervision, clear leadership and functional MDT working to support effective clinical working (BPS, 2007; Glass, 1986; NICE, 2017; Warren et al., 2009). Interestingly, given the wealth of literature on the impact of ED clinical work upon professionals' eating and relationship with food (Johnston, Smethurst, & Gowers, 2005; Shisslak, Gray, & Crago, 1989), findings did not identify this as significant. This may relate to the broad aims of the study providing limited opportunity to explore this topic. Alternatively, therapists may have felt reluctant to discuss the personal impact of their role with the researcher, which could have also prevented exploration of this topic.

The definition of ‘effective’ working, in this study, by participants was different to that originally anticipated by the researcher. Effectiveness was hypothesised to be directly associated with client recovery and related to participants’ application of therapeutic techniques, related to their therapeutic orientation. Effective working was described by participants as being able to work to the best of their ability to support clients, in spite of potential poor outcomes and other service and client-related challenges. This was not only achieved through client recovery, client outcomes or successful skill application but also through the management of positive clinical change, working to the best of their abilities, successful MDT working and both personal and service development. Their definition clearly demonstrates something important about how being effective is experienced by psychological therapists’ working with poor client outcomes, particularly in AN (Steinhausen, 2002). The emergence of such findings was facilitated by the methodological approach using broad, open-ended interview questions, allowing narratives to be easily communicated. One male participant was selected through theoretical sampling to test for potential gender differences in how working effectively with this population is experienced. Distinct differences were not identified when comparing a male narrative with those of female participants, which may indicate that therapist gender is not a factor impacting upon effective working. However, this conclusion is drawn on the basis of a single male narrative and may have been different had recruitment been more representative of both male and female participants.

The researcher did not anticipate the significance of job satisfaction and therapist development within the theoretical model prior to study commencement. The significance of the emergence of these categories led to adjustments of interview guides to allow for a richer analytical understanding. Given the lack of literature in the field, therapists were asked to discuss rewards experienced in their clinical work. As interviews and analysis progressed, job satisfaction emerged as central to therapists’ experience of effective working. Factors

associated with job satisfaction went beyond the expected rewards of the role (i.e., client recovery). Factors related more to significant experiences for them including connectedness with colleagues, personal accomplishment in working with challenge, self-affirmation, and both personal and professional development, in addition to service development. These factors support Thompson-Brenner et al.'s (2013) idea of ED work as being uniquely satisfying. Therapist personal and professional development in working with challenge was identified in early interviews. This is an interesting and significant finding, as, similarly to job satisfaction little ED research exists regarding therapist development. However, existing literature does support therapist narratives describing both personal and professional growth in this field and the importance of CPD and supervision to facilitate this (Glass, 1986; Rønnestad & Skovholt, 2003; Walker & Lloyd, 2011). Interestingly, therapists discussed growth in self-awareness regarding the personal impact of their role and the importance of self-care to enable safe working within the field. This finding supports current ED literature relating to the role of both service-related and therapist strategies in enabling effective working, specifically the clinical utility of developed self-awareness (Nutt-Williams & Fauth, 2005; Turner et al., 2014) and the importance of self-care strategies in supporting and maintaining therapist professional and personal development (Warren et al., 2012; Warren et al., 2013).

Strengths and Limitations

The findings of this study contribute to and enhance existing literature. This has been demonstrated in regards to personal and systemic factors that enable the process of effective working for ED therapists including the importance of job satisfaction (Thompson-Brenner et al., 2013; Walker & Lloyd, 2011), challenge enabling therapist development (Rønnestad & Skovholt, 2003; Turner et al., 2014) and functional MDT working (BPS, 2007; Warren et al.,

2009). A social constructionist grounded theory methodological approach allowed the researcher to work flexibly to explore and capture rich participant narratives. This led to the emergence of the theoretical model presented in this study. A particular strength of this model was its ability to represent ED therapists working in CAMHS and adult outpatient services, despite differences in client chronicity and therapeutic approach. Theoretical sampling of participants allowed for the exploration of a range of narratives across service, gender, and roles, the significance of which has been described in the findings. Walsh and Downe's (2006) quality guidelines for qualitative research were adhered to throughout the undertaking of this study.

This study explored therapist experiences of working with ED clients generally. Participants were asked to discuss their experiences of clinical working without interview questions referring to particular ED presentations. However, the researcher noted that therapists most frequently discussed AN and BN when referring to client challenge. This might be considered a limitation of the study, as a key aim was to explore clinical working with EDs, not limited to specific presentations. However, such findings were expected as they are representative of EDs regarded as most challenging to treat by professionals and within the literature. As participants frequently made no reference to specific ED presentations in their responses, the researcher understood them to be reflecting on their experiences of working with a range of ED presentations. Therefore, participant experiences reported in this study are representative of clinical working with a range of EDs, but perhaps are more reflective of AN and BN in relation to client challenges. This highlights the challenge for services in recognising, identifying and treating other EDs promptly, due to clients often not actively seeking help for their eating difficulties.

Findings of the current study are supported by existing literature but this study lacks in its reference to psychological theory. Models of effective working exist within the current

literature for non-ED MDTs but are not referenced in the current study as these models do not relate to the process of effective working and instead focus on target-driven outcomes (e.g., client outcomes) (The King's Fund, 2017). Therefore, this could be considered a further limitation of the current study highlighting the need for more theory-driven psychological research to provide evidence to inform a more comprehensive understanding of the process of effective working for psychological therapists.

Theoretical sampling allowed for the exploration of similarities and differences in the experiences of a range of ED therapists. Despite this, a notable lack of ethnic diversity can be observed across recruited participants, which could be considered as another limitation of the study. Although qualitative research does not aim to recruit a fully representative participant sample or generalisable findings, a participant sample representing a number of ethnic groups would have enriched findings. Future qualitative research should endeavour to capture the experiences of a more representative ethnically diverse participant sample, which may offer further insights about how effective working is experienced by psychological therapists.

Clinical Implications

Study findings have clear clinical implications regarding the resources required by therapists to achieve effective working. Services' ability to provide such resources to support therapists in their role will also impact on their ability to retain these professionals in employment. Service managers and commissioners for both CAMHS and adult ED services should be aware of the following resources for therapists, which will enable effective clinical working and increase the overall quality of service provision for clients and families. Accessible and adequate clinical supervision to process and problem-solve clinical and service-related challenges should be prioritised for therapists. Creating regular, allocated MDT clinical space, through meetings, reflection, and discussion, to allow for

communication about clinical and service-related challenges will enhance cohesive working. As clinical supervision is limited, resources to enhance cohesive team working will support therapists in providing further opportunity for them to seek regular support and informal supervision with colleagues. Enabling CPD opportunities to ensure therapists are acquiring up-to-date ED-specific knowledge and training in their therapeutic modality will increase their confidence and development of therapeutic approach. Services must ensure stability and clear communication through liaising with other external agencies and professionals to create clear referral and treatment pathways and protocols. This will enable therapists to clearly define their professional roles (NICE, 2017). CAMHS therapists highlighted the importance of services being able to carefully consider the impact of service re-structuring on therapist and service functioning. Services should do their utmost to consult with therapists, listen to them and respond to their feedback regarding service development. This will ensure transparency of working and high-quality services, with safe working environments. Therapists should be aware of the importance of supporting their personal wellbeing whilst working with this both challenging highly rewarding client group. In developing an awareness of how their role impacts upon them personally and also professionally, psychological therapists will be more able to implement appropriate strategies relating to self-care and asserting their needs, to maintain wellbeing and a healthy work-life balance.

Future Research

Future research could continue to further develop and strengthen the presented theoretical model to investigate its applicability to experiences of inpatient–based ED therapists or even to other professional disciplines working within ED services (e.g., dietetics, psychiatry). Research could also quantitatively explore specific areas of the model to investigate the strength of association between categories to inform professional thinking

and develop interventions and training to enable safe and effective working with ED clients.

Therapists who participated in this study all described, to some degree, experiencing job satisfaction in relation to their role. Staff turnover within ED services can be high. Therefore, it would be of benefit for future research to qualitatively investigate the experiences of ED therapists who have exited from their post or who have experienced burnout as a consequence of their role. This would allow for comparison of the factors impacting upon this group of therapists' poor experiences with those, as in this study, having more positive work-related experiences leading to effective working and continuation in their role.

Conclusion

Therapist narratives clearly highlight the impact of therapist, service-related and unique treatment factors upon effective working. Findings identify first that challenge is regarded as pivotal in facilitating therapist and also service development, leading to strengthened effective working and professional identity. Second, that job satisfaction is fundamental to increasing therapists' motivation and ability to work with challenge. Findings clearly identify the specific support and resources required by ED therapists to work effectively in their role. Importantly, they also highlight functional MDT working as essential to the management of the clinical challenges experienced by therapists.

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Appendix A: Psychology & Psychotherapy: Theory, Research & Practice author guidelines

Psychology and Psychotherapy: Theory Research and Practice is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds.

Length

All articles submitted to PAPT must adhere to the stated word limit for the particular article type. The word limit does not include the abstract, reference list, figures and tables. Appendices however are included in the word limit.

Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 6000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

Submission and reviewing

All manuscripts must be submitted via Editorial Manager. The Journal operates a policy of anonymous (double blind) peer review.

Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

- Manuscripts should be preceded by a title page, which includes a full list of authors and their affiliations, as well as the corresponding author's contact details.

- The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.

- Tables should be typed in double-spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.

- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions

should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.

• For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.

• All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professional practice.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

• Manuscripts describing systematic reviews and meta-analyses must be submitted in accordance with the PRISMA statement on reporting systematic reviews and meta-analyses (http://www.prisma-statement.org).

Retrieved from:
https://onlinelibrary.wiley.com/page/journal/20448341/homepage/forauthors.html

Appendix B: Attachment styles/patterns conceptualisation across measures

Retrieved from Schindler & Broning (2015)

Measure	**Strange Situation**	**Adult Attachment Interview**	**Hazan & Shaver Self Report (HSSR)**	**Bartholomew Interview/Relationship Questionnaire (RQ)**
Age	Infants and children	Adolescents and adults	Adolescents and adults	Adolescents and adults
Level of attachment security				
Secure	Secure (B)	Secure-autonomous	Secure	Secure
Insecure (insecure coping strategies)	Insecure-avoidant (A)	Insecure-dismissing	-	Dismissing-avoidant
	Insecure-ambivalent (C)	Insecure-preoccupied	Anxious-ambivalent	Preoccupied
Lack of coping strategies/	-	-	Avoidant	Fearful-avoidant
Disorganised	Disorganised	Unresolved loss or trauma Hostile-helpless Cannot classify	-	-

Appendix C: Email to authors

Sent: Friday, December 8, 2017
Subject: Research query for ongoing systematic review

Dear Professor XXX,

We are currently undertaking a systematic review of the research literature concerning the relationship between mental health professionals' attachment style and burnout or compassion fatigue or other closely associated constructs (e.g. vicarious trauma, shared traumatic stress, secondary traumatic stress).

During our literature search we identified your paper, entitled "XXXXXX", which appears relevant to our review. I am emailing to check if you have undertaken any further work, either published or unpublished, which meets the following criteria:

- Uses a quantitative measure of attachment and burnout or compassion fatigue or other closely associated constructs (as mentioned above)
- The association between attachment style and burnout or compassion fatigue or other closely associated constructs data is analysed
- Population data is obtained from mental health professionals

If so, we would greatly appreciate it if you could send us any articles/reports relating to this work to consider for inclusion in this review.

I look forward to hearing from you,

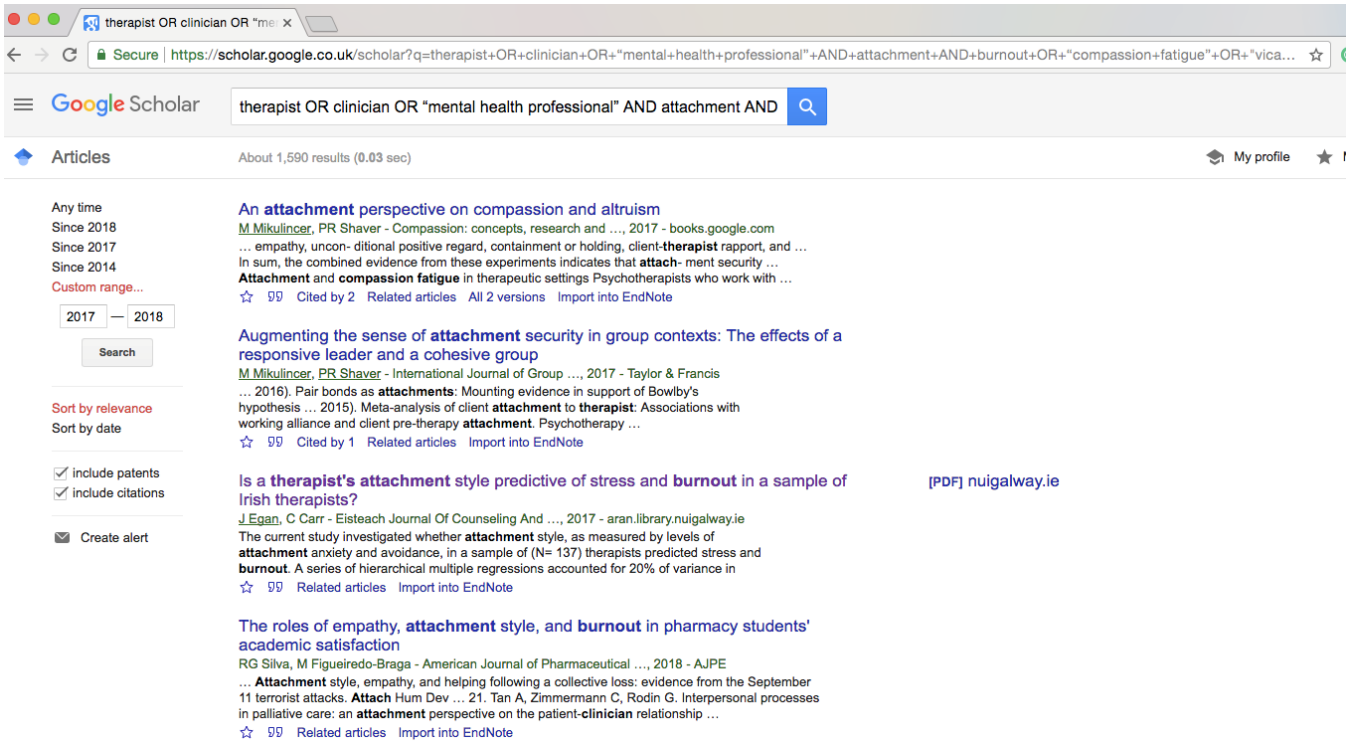
Best wishes,

XXXXX (Trainee)

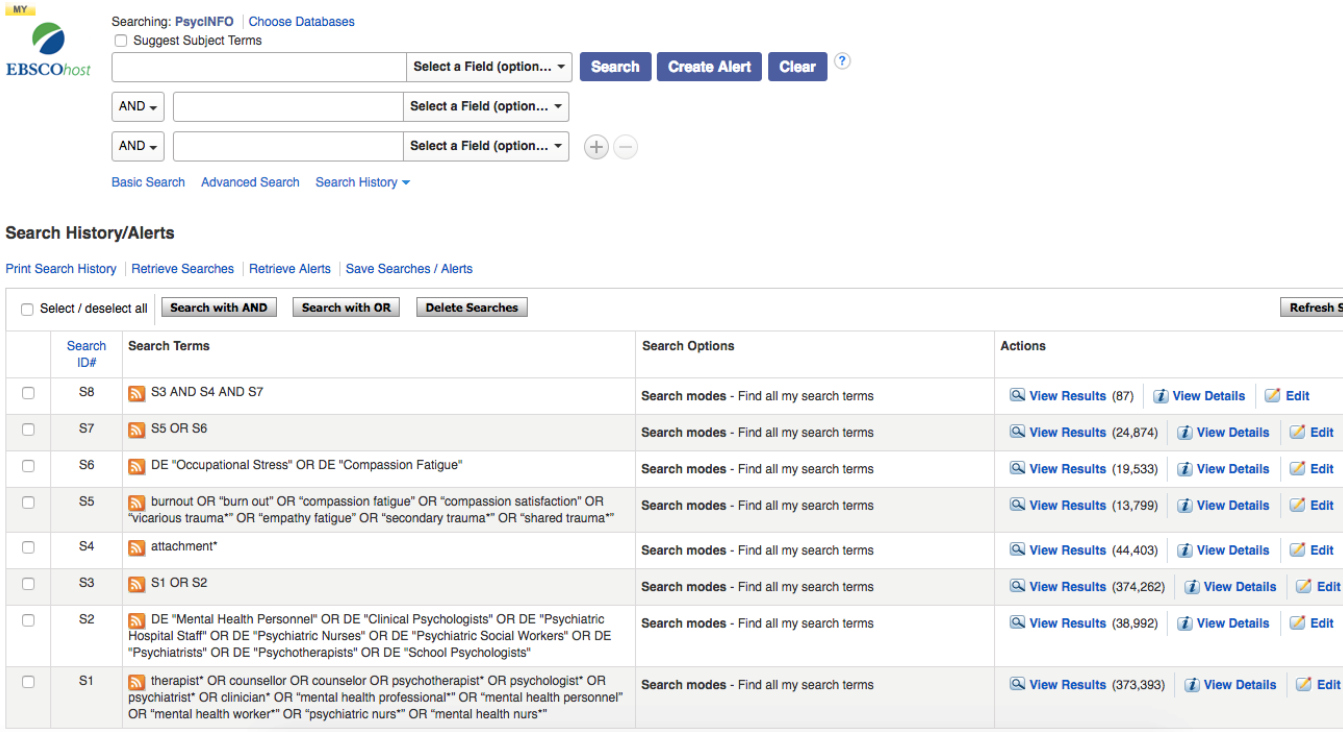
Appendix D: Google scholar search

Google Scholar search terms: therapist OR clinician OR “mental health professional” AND attachment AND burnout OR “compassion fatigue” OR "vicarious trauma" OR "secondary trauma" OR “shared trauma” OR “empathy fatigue”

Searched: custom range 2017- 2018



Appendix E: Controlled vocabulary search for PsycINFO



Note. Controlled vocabulary terms were as follows: (“mental health personnel” OR “clinical psychologists” OR “psychiatric hospital “ OR “psychiatric nurses” OR “psychiatric social workers” OR “psychiatrists” OR “psychotherapists” OR “school psychologists”) AND (“occupational stress” OR “compassion fatigue”)

Appendix F: Quality assessment of included studies using the AHRQ (Williams et al., 2010; Taylor et al., 2015) in order of ratings

Author (year)	Unbiased selection of cohort	Sample size calculation/ justification	Adequate description of the cohort	Validated method to assess attachment style?	Valid method to assess negative personal outcome	Researcher effects as non-impacting	Minimal missing data	Control of confounders	Analysis appropriate
Tosone, Bettman, Minami & Japerson (2010)	Partially	Yes	Yes	Yes	Yes	Yes	Cannot tell	Partially	Partially
Tosone, McTighe, Bauwens, Naturale (2011)	Partially	Partially	Partially	Yes	Partially	Yes	Cannot tell	Yes	Partially
Tosone, McTighe & Bauwens (2015)	Partially	No	Yes	Yes	Partially	Yes	Cannot tell	Yes	Partially
Carr & Egan (2017)	Partially	No	Partially	Partially	Yes	Yes	Partially	Partially	Partially
Burrell, McFarlance, Tandon, Fuddy & Duggan (2009)	Partially	No	Yes	Yes	Yes	Partially	Cannot tell	No	Partially
Racanelli (2005)	Partially	No	Partially	Partially	Partially	Yes	Cannot tell	Partially	Partially
Zerach (2013)	Partially	No	Yes	Yes	Yes	Partially	Cannot tell	No	Cannot tell
Hartley, Jovanoska, Roberts, Burden & Berry (2016)	Partially	Cannot tell	Yes	Yes	Partially	No	Cannot tell	No	Partially
Marmaras, Lee, Siegal amd Reich (2003)	Cannot tell	No	Yes	Partially	Partially	Cannot tell	Cannot tell	No	Cannot tell

Appendix G: British Journal of Psychology author guidelines

The *British Journal of Psychology* publishes original research on all aspects of general psychology including cognition; health and clinical psychology; developmental, social and occupational psychology. For information on specific requirements, please view Author Guidelines.

Author Guidelines

The Editorial Board of the British Journal of Psychology is prepared to consider for publication:

(a) reports of empirical studies likely to further our understanding of psychology
(b) critical reviews of the literature
(c) theoretical contributions Papers will be evaluated by the Editorial Board and referees in terms of scientific merit, readability, and interest to a general readership.

All papers published in The British Journal of Psychology are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

1. **Circulation**

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. **Length**

Papers should normally be no more than 8000 words (excluding the abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. **Submission and reviewing**

All manuscripts must be submitted via Editorial Manager. The Journal operates a policy of anonymous (double blind) peer review. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the terms and conditions of submission and the declaration of competing interests. You may also like to use the Submission Checklist to help you prepare your paper.

4. **Manuscript requirements**

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. You may like to use this template. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the Project CRediT website for a list of roles.

• The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.

• All articles should be preceded by an Abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

If you need more information about submitting your manuscript for publication, please email Vicki Pang, Editorial Assistant (bjop@wiley.com) or phone +44 (0)1243 770 410.

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Appendix H: Letters of approval from D.ClinPsy research review committee, University ethics committee, NHS trust and University sponsorship team

D.ClinPsy Research Review Committee approval letter

UNIVERSITY OF LIVERPOOL

D.Clin.Psychology Programme
Division of Clinical Psychology
Whelan Building, Quadrangle
Brownlow Hill
LIVERPOOL
L69 3GB

Tel: 0151 794 5530/5534/5877
Fax: 0151 794 5537
www.liv.ac.uk/dclinpsychol

15th August 2016

Stephanie Keith
Clinical Psychology Trainee
Doctorate of Clinical Psychology Doctorate Programme
University of Liverpool
L69 3GB

RE: A grounded theory study of personal and systemic factors that impact on clinical working with eating disorders: a therapist perspective
Trainee: Stephanie Keith
Supervisors: Dr Kate Bennett, Dr Irina Yelland

Dear Stephanie,

Thank you for your response to the reviewers' comments of your research proposal submitted to the D.Clin.Psychol. Research Review Committee (letter dated 18/07/16).

I can now confirm that your amended proposal (version 2, date 22/07/16) and revised budget (no version number, dated 19/07/16) meet the requirements of the committee and have been approved by the Committee Chair.

Please take this Chairs Action decision as ***final*** approval from the committee.

You may now progress to the next stages of your research.

I wish you well with your research project.

Dr Catrin Eames
Vice-Chair D.Clin.Psychol. Research Review Committee.

University of Liverpool Ethics Committee approval letter

Health and Life Sciences Committee on Research Ethics (Psychology, Health and Society)

9 December 2016

Dear Dr Bennett,

I am pleased to inform you that your application for research ethics approval has been approved. Details and conditions of the approval can be found below:

Reference:	0692
Project Title:	A grounded theory study of personal and systemic factors that impact on clinical working with eating disorders: a therapist perspective
Principal Investigator/Supervisor:	Dr Kate Bennett
Co-Investigator(s):	Miss Stephanie Keith
Lead Student Investigator:	-
Department:	Psychological Sciences
Reviewers:	Dr Georg Meyer, Dr Alexis Makin
Approval Date:	09/12/2016
Approval Expiry Date:	Five years from the approval date listed above

The application was APPROVED subject to the following conditions:

Conditions

- All serious adverse events must be reported via the Research Integrity and Ethics Team (ethics@liverpool.ac.uk) within 24 hours of their occurrence.
- If you wish to extend the duration of the study beyond the research ethics approval expiry date listed above, a new application should be submitted.
- If you wish to make an amendment to the research, please create and submit an amendment form using the research ethics system.
- If the named Principal Investigator or Supervisor leaves the employment of the University during the course of this approval, the approval will lapse. Therefore it will be necessary to create and submit an amendment form using the research ethics system.
- It is the responsibility of the Principal Investigator/Supervisor to inform all the investigators of the terms of the approval.

Kind regards,

Health and Life Sciences Committee on Research Ethics (Psychology, Health and Society)

iphsrec@liverpool.ac.uk

0151 795 5420

NHS trust approval: SPEAR and Letter of Access

[redacted] [redacted] NHS Trust

Research Office

[redacted]

Standardised Process for Electronic Approval of Research

13th January, 2017

Stephanie Keith
Doctorate in Clinical Psychology
The University of Liverpool
Division of Clinical Psychology
The Whelan Building - The Quadrangle
Brownlow Hill
Liverpool
L69 3GB

Dear Stephanie,

Re: NHS Permission for Research

Project Title: A grounded theory study of personal and systemic factors that impact on clinical working with eating disorders: a therapist perspective.
Sponsor: University of Liverpool
SPEAR: 1506

Further to your request for permission to conduct the above research study at this Trust, we are pleased to inform you that this Trust has given NHS permission for the research to proceed.

Your NHS permission to conduct research at this site is only valid upon receipt of a signed 'Conditions for NHS Permission Reply Slip' which is enclosed.

Please take the time to read the attached conditions for NHS permission. Please contact the Research Office should you require any further information. You will need this letter as proof of NHS permission.

NHS permission for the above research has been granted on the basis described in your university application form and supporting documentation.

The documents reviewed were:

- University ethics application, D.Clin.Psych approval 15/08/2016, University of Liverpool ethics approval 09/12/2016
- Protocol, v2, 22/07/2016
- Participant information sheet, v1.2, 13/12/2016
- Consent form, v1, 01/09/2016

[redacted]

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP (if applicable), and NHS Trust policies and procedures. Permission is only granted for the activities for which a favourable opinion has been given by the Ethics Committee (where appropriate).

May I wish you every success with your research.

Yours sincerely,

[redacted]

Dr [redacted]
Senior Research Facilitator on Behalf of:

PP Dr [redacted]
Research and Effectiveness Manager

Enc: Approval Conditions Leaflet

[redacted]

[redacted] [redacted] NHS Trust

Study Title: A grounded theory study of personal and systemic factors that impact on clinical working with eating disorders: a therapist perspective.

Conditions for NHS Permission Reply Slip: for reference.

In order for your NHS permission to be valid, please return this form to the address below to confirm that you have read and understood the conditions of NHS permission to conduct research.

1. I confirm that I have read and understand my duties and responsibilities as part of the conditions for permission to conduct research at this site.
2. I understand that I must submit the following information to the Trust's R&D department:
    - Recruitment figures on a monthly basis
    - New researcher details prior to them commencing on the research project
    - Any amendments submitted to the Ethics Committee
    - Changes to the status of the research project
    - Any urgent safety measure incorporated
    - Untoward Incidents and Unexpected Events within 24 hours of their occurrence
    - A final summary report
    - A copy of the Ethics letter confirming receipt of the End of Study Declaration
3. I understand I must complete and return in a timely manner any audit forms sent to me by the Trust.
4. I understand that I must gain permission from the Trust in order to publish or place information of the current research into the public domain.

[redacted]

[redacted]

[redacted] NHS
[redacted] Trust

[redacted]

13th January, 2017

Stephanie Keith
Doctorate in Clinical Psychology
The University of Liverpool
Division of Clinical Psychology
The Whelan Building - The Quadrangle
Brownlow Hill
Liverpool
L69 3GB

Dear Stephanie,

Re: Letter of Access

Project Title: A grounded theory study of personal and systemic factors that impact on clinical working with eating disorders: a therapist perspective.
Sponsor: University of Liverpool
SPEAR: 1506

We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research through [redacted] **Trust** for the purpose and on the terms and conditions set out below. This right of access commences **16th January, 2017** and ends on **31st December, 2017**, unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to [redacted] **Trust** premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through [redacted] **Trust**, you will remain accountable to your employer **University of Liverpool/**[redacted], but you are required to follow the reasonable instructions of your nominated manager [redacted] **Research and Effectiveness Manager** in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance [redacted] **Trust** with policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with [redacted] **Trust** in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on [redacted] **Trust** premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

[redacted] **Trust** will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Where applicable, your substantive employer will initiate your Independent Safeguarding Authority (ISA) registration in-line with the phasing strategy adopted within the NHS and the applicable legislation. Once you are ISA-registered, your employer will continue to monitor your ISA registration status via the on-line ISA service. Should you cease to be ISA-registered, this letter of

[redacted]

access is immediately terminated. Your substantive employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or ISA registration, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

[redacted]

Dr [redacted]
Senior Research Facilitator

[redacted]

University of Liverpool Sponsor Permission to Proceed Letter

Dr Kate Bennett
Institute of Psychology, Health and Society
University of Liverpool
Waterhouse Building Block B
3 Brownlow Street
Liverpool
L69 3GL

Mr Alex Astor
Head of Research Support – Health and Life Sciences

University of Liverpool
Research Support Office
2nd Floor Block D Waterhouse Building
3 Brownlow Street
Liverpool
L69 3GL

Tel: 0151 794 8739
Email: sponsor@liv.ac.uk

01 February 2017

Sponsor Ref: UoL001250

Re: Sponsor Permission to Proceed notification

"A grounded theory study of personal and systemic factors that impact on clinical working with eating disorders: a therapist perspective"

Dear Dr Bennett

All necessary documentation and regulatory approvals have now been received by the University of Liverpool Research Support Office in its capacity as Sponsor, and we are satisfied that all Clinical Research Governance requirements have been met. You may now proceed with any study specific procedures to open the study.

The following ethically Approved documents have been received by the Research Support Office. Only these documents can be used in the recruitment of participants. If any amendments are required please contact the Research Support Office.

Document title	Version	Date
Research Proposal	2	22nd July 2016
Participant Consent Form	1	1st September 2016
Participant Information Sheet	1.2	13th December 2016
Interview Schedule	1	5th September 2016

Please note, under the terms of your Sponsorship you must;

1. Gain NHS Confirmation of Capacity and Capability from each participating site before recruitment begins at that site;

2. Ensure all required contracts are fully executed before recruitment begins at any site;

3. Inform the Research Support Office as soon as possible of any adverse events especially SUSARs and SAE's, Serious Breaches to protocol or relevant legislation or any concerns regarding research conduct;

4. Approval must be gained from the Research Support Office for any amendments to, or changes of status in the study **prior to** submission to REC and any other regulatory authorities;

5. It is a requirement that you submit annual reports to the Sponsor annually from the date of Sponsorship Approval. The report proforma can be obtained from the Research Support Office webpages. You must also provide copies of any reports submitted to Ethics Committees and any other regulatory authorities to the Research Support Office;

6. Maintain the study master file;

7. Make available for review any study documentation when requested by the sponsors and regulatory authorities for the purposes of audit or inspection;

8. Upon the completion of the study it is a requirement that you submit an End of Study Declaration (within 90 days of the end of the study) and End of Study Report (within 12 months of the end of the study) to the Sponsor. The End of Study Declaration proforma can be obtained from the Research Support Office webpages. You must also provide copies of any reports submitted to Ethics Committees and any other regulatory authorities to the Research Support Office;

9. Ensure you and your study team are up to date with the current RSO SOPs throughout the duration of the study.

If you have any queries regarding the sponsorship of the study please do not hesitate to contact the Clinical Research Governance Team on 0151 794 8373 (email sponsor@liv.ac.uk).

Yours sincerely

Mr Alex Astor
Head of Research Support – Health and Life Sciences
Research Support Office

Appendix I: Participant information sheet

Participant Information Sheet

Project Title: A grounded theory study of personal and systemic factors that impact on clinical working with eating disorders: a therapist perspective

You have been invited to take part in the above study, being conducted as part of a Doctorate in Clinical Psychology postgraduate qualification. Before you make a decision to participate or not, please consider the following information provide to help inform your decision.

What is the purpose of this study?
To understand the rewards and challenges experienced by therapists working within the eating disorders field and how these things can impact upon clinical working. It is hoped that at the end of the study, a theoretical model will be developed to better understand the factors that allow eating disorder therapists work effectively despite challenges in their clinical role.

Why have I been invited?
Because you are a psychological therapist working within a XXXXXXXX NHS Trust outpatient setting, who works clinically with eating disorder clients.

Do I have to take part in the study?
You do not have to take part. Your participation is completely voluntary.

What will I be asked to do if I agree to take part?
You will be invited to take part in a 1:1 interview with the lead researcher. During this interview, you will be asked questions in relation to your experience as a therapist working with eating disorder clients. The interview will take place at your place of work. Before the interview commences, you will also be asked to provide a small amount of information to help inform the interview selection process.

How much time will participation involve?
The interview will last no longer than one hour. A small amount of correspondence with the lead researcher prior to interviews, to obtain some basic details will be required.

Reimbursement
Your participation in this study will be reimbursed with a £20 gift voucher.

What are the possible disadvantages of taking part?
You may feel uncomfortable discussing the challenges you have experienced during you experience working therapeutically with clients.

What are the possible benefits of taking part?
You will contribute to increasing the research evidence base to support your profession, by identifying the professional support required by eating disorder therapists. Also, you may enjoy reflecting on the rewards and challenges within your role as a therapist and on the factors that support/hinder you in this role.

What if there is a problem?
You will be provided with the details of the lead researcher, who will support you should there be any problems throughout your involvement in this study.

Will my taking part in the study be kept confidential?
In accordance with the Data Protection Act (1998), all of the data collected as part of this study will have all personal, identifiable information removed before data analysis commences. Your involvement in this study will remain confidential and your name will not be recorded on any associated documents.

What will happen if I don't carry on with the study?
If you choose to participate and then at a later date decide you no longer wish to continue, you can withdraw from the study at any time. You are not obligated to explain to the lead researcher why you no longer wish to participate. Your withdrawal from this study will be respected and you will not be contacted after this time.

What will happen to the results of the research study?
The results of this study will be shared with all participants in the form of a short report. Results will also be shared with the individual services involved in this study, once consent is gained from participants. All results will remain confidential.

Who is organising and sponsoring the research?
The lead researcher is responsible for the organisation of this study, which is sponsored by the University of Liverpool.

What happens now?
If you would like to take part in this study please complete and return the attached response slip to the lead researcher in the pre-paid envelope provided. Alternatively, you can e-mail this information directly to the lead researcher using the e-mail address below. Once your information is received, the lead researcher will contact you to arrange to meet at a time that is convenient for you. If you would not like to take part then you do not have to do anything further. If you have any further questions regarding participating in this study then please feel free to contact the lead researcher using the contact information below.

Contact details
Lead Researcher: Stephanie Keith
Trainee Clinical Psychologist, University of Liverpool

E-mail: Stephanie.keith@liverpool.ac.uk
Address: Doctorate in Clinical Psychology Programme. University of Liverpool, Whelan Building, Liverpool, L69 3GB

Response slip

Project Title: A grounded theory study of personal and systemic factors that impact on clinical working with eating disorders: a therapist perspective

Dear Stephanie,

I confirm that I would like to participate in the above study and I am happy to be contacted for further arrangements to be made for my involvement in this study (i.e. interview date and time).

My contact details

Full name: ……

Service of employment: ……

E-mail address: ……

Tel: ……

The most convenient times to be contacted during 9-5pm working hours for me are (please circle):

Monday	AM	PM
Tuesday	AM	PM
Wednesday	AM	PM
Thursday	AM	PM
Friday	AM	PM

Please return this response slip in the pre-paid envelope that provided was provide along with the information sheet for this study. Thank you, Stephanie

Appendix J: Consent form

PARTICIPANT CONSENT FORM

Title of Research Project: A grounded theory study of personal and systemic factors that impact on clinical working with eating disorders: a therapist perspective

Researcher: Stephanie Keith

	Please initial box
1. I confirm that I have read and have understood the information sheet dated 1st September 2016 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, without my rights being affected. In addition, should I not wish to answer any particular question or questions, I am free to decline.	☐
3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish.	☐
4. I understand and agree that my participation will be audio recorded and I am aware of and will consent to your use of these recordings for the purposes of data analysis for this research study.	☐
5. I understand that confidentiality and anonymity will be maintained and it will not be possible to identify me in any publications and I agree to the use of anonymised quotes in publications in relation to this research study.	☐
6. I agree to take part in the above study.	☐

Participant Name	Date	Signature
Researcher	Date	Signature

Principal Investigator:
Name: Kate Bennett
Work Address: Eleanor Rathbone Building, Liverpool, L69 7ZA
Work Telephone: 0151 7941410
Work Email: kmb@liv.ac.uk

Post-Graduate Student Researcher:
Name: Stephanie Keith
Work Address: Whelan Building, Liverpool, L69 3GB
Work Telephone 0151 794 5530
Work Email: s.keith@liv.ac.uk

[Version 1; Date: 01/09/2016]

Appendix K: Interview guide and adjustments

Cover Note

Original interview guide is presented below with amendments made to it at two time points (post interview 6 and 10).

Key

Schedule for 1.2 interview guide = yellow

Schedule addition/adjustment for 1.3 interview guide = green

Strikethrough = deletion

Arrows = question moved

Interview guide

Thank you for agreeing to talk about your experiences as an eating disorder therapist and the rewards challenges that arise within this role. As we have discussed, I am interested in the factors that support you to work effectively in your role. I am interested in your own personal experiences, which may be different from other people, so please tell me about your experiences only. This interview will probably last around one hour. I would like to audio record this interview with your permission. We will be able to arrange an opportunity for you to hear the tape back if you would like. I can assure you that our discussions within this interview will remain confidential.

I would like to start by asking you half a dozen factual questions and then go on to ask you more open questions about the challenges you have faced working as an eating disorder therapist.

Section A: Demographics and factual information

What is your gender?

What is your age?

What is your job title?

What is your therapeutic orientation? (e.g. behavioural, psychodynamic…)

How many years have you been qualified as a therapist?

How many years have you worked in the eating disorders field?

What is your position in this service? ~~your current team?~~ (e.g. senior management, senior therapist, newly qualified)

Do you work full or part time?

How would you describe the current service you work within?
(e.g. CAMHS, AMH, ~~TIER 4…~~)

Is this the only service you currently work within?
If no, Can you tell me a bit more about the other service(s) you work within?

Section B: Eating disorders

I would now like to ask you about you role and the field you are currently working within.

"It has been recognised that working as a therapist within the field of eating disorders can be particularly challenging for a number of reasons."

How do you feel about this statement? Do you agree? Disagree?

~~**If yes, what do you think makes this more of a challenge compared to working with other client groups?**~~

~~**If not, why not?**~~

More challenging compared with other areas of mental health?

What are the challenges that you face in your job role?

- Positive challenges (e.g. professional growth, satisfaction, support, varied caseload)
- Negative challenges
  (*prompt if required: what supports you to manage challenge?)*

Section C: Service structure

I would like to ask you about the structure of the service you working within.

How do you ~~manage~~ experience service-related pressures/demands in your role in regards to NHS ~~from~~ trust/senior management ~~within NHS trust~~/NHS England? (e.g. number of sessions, waiting times, ~~requests for inpatient beds,~~ commissioning standards, higher management, staffing)

How are you able to manage these pressures/demands? (e.g. personal/service resources?)

How do you feel that such pressures impact upon your clinical work and how you perform in your role?

If yes, how does this affect your clinical work? Your experience of your job role?

If no, why do you think this may be? How does you current team support you in this?

~~**How do you experience pressure in your role in regards to NHS demands?** (e.g. waiting lists, commissioning standards)~~

Section D: Team Support

I would now like to ask you about the team would work within.

How would you describe the cohesion of your team? (e.g. supportive, strained, uncontained)

Tell me about some of the ways you feel supported ~~/unsupported~~ by your team/colleagues/ managers in your role as a therapist? (i.e., *how* do they offer you support? Informal/formal? Supervision, case discussion)

Tell me about some of the ways you feel unsupported by your team/colleagues/managers in your role as a therapist? (if so thoughts on why?)

How do you experience working within your current team?

~~**How do you feel the colleagues in your team offers support to you in your role as a therapist?**~~

- ~~What support is offered? (e.g. supervision, case discussion, informal support)~~

~~**If no, why do you think that this may be the case?**~~

Section E: Clients

I would like to now ask you specifically how you experience working with this client~~s~~ group.

When thinking about ED type, ~~What~~ which presentation ~~of eating disorder~~ do you most ~~frequently~~ prefer to work with? Can you tell me why this may be? – Question deleted

~~**Is this a presentation you prefer to work with?**~~
~~**If yes, why yes?**~~
~~**If no, what presentation of eating disorder are you most comfortable working with?**~~

Can you tell me what you feel the most challenging aspect of working with this client group is? (Therapeutic factors? client factors? evidence-base? risk?) (*prompt if required*: what supports you to manage challenge?)

Could you talk about professional development associated with your role (to manage challenge)? (*limited evidence base, commissioning, smaller caseload, MDT working, reflection, increased supervision*)

Tell me how you feel about working with risk presenting in eating disorders? (e.g. confidence, ability, fears) - feeling supported in this?

Do you feel supported in your decision-making regarding risk? (e.g. containment of team, support of colleagues, senior management) - Question deleted

Could you talk about the concept of responsibility in your clinical work? *(therapist, team, client)*

Section F: Therapist factors

I would now like to ask you about yourself as a therapist.

Can you tell me about how you feel working within an eating disorder service?
(e.g. general job satisfaction, work-life balance)

Can you tell me about any feelings that arise for you when working with this client group?

In thinking about potential personal development, ~~H~~ how do you think your clinical work has made you reflect on yourself, your own body image and relationship with food?

- Impact on lifestyle? Exercise? Diet?
- Awareness of self and others
- Societal

Can you tell me how working with this client group has impacted upon your~~r~~ personally? ~~levels of self-care?~~

- Self-care
- Work-life balance/imbalance
- Relationships: Personal/friendship/family/colleagues

Can you talk ~~a bit more~~ about how you are able to manage the emotional challenges that this job brings?

What do you find the most rewarding part of your role to be?

What do you find the most unrewarding part of your role to be?

Section G: Tips for other therapists

If you could give tips to other therapists embarking upon a career working with eating disorders, what would your advice be to them? - Question deleted

Can you say a little about what you have learnt most in regards to working within the eating disorders field? - Question deleted

Appendix L: Reflexive statement

I am a trainee clinical psychologist completing a piece of empirical research for my professional doctorate qualification. I have worked in the mental health field for the past eight years, two and a half years of which have been spent working specifically with an ED population. My previous clinical experience of ED work was as an assistant psychologist working with adolescents in an outpatient setting.

My clinical experience has increased my awareness of some of the negative and positive challenges of working within the ED field. I have observed colleagues (psychological therapists) working both successfully and not so successfully with a range of client groups, across different mental health settings. I have heard colleagues comment on how much they either really enjoy or really do not enjoy working with EDs. Such a striking difference in opinions has led me to question why this may be. I have often wondered about the factors that may relate to this: the person (colleague), client challenges and team. It made me really think about the impact of personal and systemic factors on ED therapists and which factors both helped and hindered them in their role.

I am aware that my views on working with this client population have been constructed through my experiences as an assistant psychologist. This was a role in which I was protected and shielded by my supervisors from the many challenges of ED clinical, including therapeutic, work. I am also aware that my personal enjoyment of this role working alongside a highly skilled, specialist ED team led me to develop an interest in this particular research area. It is conceivable that my previous clinical experience has influenced my perception of this research topic. I have identified some personal assumptions that may have influenced the research process had I not reflected on them prior to commencing my research. These include: ED therapists, 'receive lots of support and time for reflection with colleagues', 'feel contained by the team around them at all times', 'experience high levels of satisfaction in their work' and 'feel confident in their clinical approach and know what they are doing', 'achieve good outcomes with clients', 'are not subject to clinical pressures' and 'hold small caseloads'.

There are a number of ways in which I aim to minimise the impact of these assumptions throughout the research process, allowing me to fully explore and understand each participant's experience including; taking a non-assumptive, curious approach to interviews, line-by-line coding, reflection in supervision and writing memos.

Appendix M: Memo examples

16th July 2017 (general): I can really feel myself grappling with this methodological approach in terms of course demands and where I currently am with the project. I am noticing that I am imagining the next stages of analysis, beyond initial coding, to be something really complicated. However, when I become immersed in the data the progression of the analysis process seems natural. I am enjoying conducting interviews and analysis. I only wish there was more time to make headway with analysis and theory development. As we have one day per week for research it feels a bit "stop-start". I must be clear on my approach to analysis to gain clarity for the time it will take to protect my work-life balance.

12th August 2017 (general): Wondering about what my findings will show. Will the theory discover something quite different about how ED therapists manage their role effectively? This is an important area of research because although they face similar challenges to other mental health professionals/therapists the complexity and challenges they work with (re: risk, evidence base) is objectively different. Little research in this area has investigated this from a therapist's perspective, which is interesting given the high turn over of staff of ED services in an NHS where resources are shrinking.

14th November 2017 (final interviews approaching): It feels like a model is coming together. My model does have good face validity, as discussed with an expert by experience and supervisor over the past few weeks. However, I really wanted to find something 'different and special' in my research. Reflecting on this, I think that I have developed something that can contribute to existing research and inform the thinking of mental health professionals. Perhaps me thinking this is reflective/confirming my knowledge based on previous ED experience. I feel like these is a 'tension' for me to get the model 'right' with my final two interviews in testing the model. I feel I am modelling the perfectionism discussed about clients in my interviews.

January 3rd 2018 (therapist development): Thinking about this category now as something different to what I have been holding in mind over the past few weeks, as analysis has progressed. Development for these therapists is not just about engaging with CPD activities (e.g. training, reading) but is experienced through the continual development of existing (or sometimes new) professional/personal skills. In describing ways of working with challenge, therapists spoke about both general therapy and professional skills/strategies/approaches they use to work with challenge in their role leading to development. Therapists didn't solely focus upon the application of specific therapeutic skills (e.g. relapse prevention, circular questioning) in session with clients, in response to interview questions. They also discussed their approaches to working with a number of clinical challenges and difficult process factors associated with this role. Examples of ways of effective working including also their personal development, in relation to their role to enhance development include: bearing emotion & uncertainty, boundaries, risk assessment and management, MDT liaison, confidence in own ability, holding realistic therapy goals, appreciating small therapeutic change. Working with EDs continually strengthens these skills.

Appendix N: Interview summary example

Interview Narrative

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Diagrammatic Summary

Interview Critique

<u>Interviewee</u>

- Engaged
- Struggled to articulate personal impact of role – is this a lack of awareness or ability to reflect or did she not want to say? Have noticed this occurring within other interviews.
- Used humour throughout interview - perhaps felt embarrassed talking about self as interview was being recorded?

<u>Myself</u>

- Good mix of open and enquiring questions. Unsure if some questions were leading, unintentionally as using them in a way to confirm/disconfirm theory ideas/hypotheses gathered from previous interviews.
- Tricky to balance interview demands to:- allow participants to speak, listen, hypothesise, keep to time and progress through interview guide.
- Interview style evolving noticing that I am becoming more skilled in asking questions with a focus to develop theory.

Ideas/Hypotheses/themes emerging

Therapist traits allowing therapist to rise to challenge of role and working with complexity

ED as a challenging field
Managing dual risk adds to complexity/uniqueness of intervention
Therapist anxiety linked to high mortality in ED clients
Therapist anxiety relating to medical professionals lacking clarity in risk management
Rewards being defined than outcomes other than "recovery"
Poor outcomes meaning opportunities to recognise good outcomes in other ways
Smaller caseload enabling more opportunity for meaningful change
Client presentation providing opportunity for professional development
Humour with colleagues as a means of alleviating clinical pressures
Sense of achievement of skill development as being gained through complexity of ED severity and presentation
Lack of self-care increasing therapist vulnerability to burnout

Appendix O: Analysis procedure and audit trail

1. Post-interview write an interview summary: *interview narratives, critique, hypotheses/ideas/themes emerging, diagramming, future thinking (+memos).*
2. Anonymise and format transcript and transfer into Excel spreadsheet.
3. Listen to interview audio – make notes in summary column on Excel spreadsheet. Note any potential abstract codes/themes/focused codes.
4. Complete line-by-line coding onto Excel spreadsheet. Code <u>action and also anything of interest.</u>
5. During this coding stage identify significant quotes (*highlight in red*). Refer back to these during theory development.
6. Focused coding: group significant initial, line-by-line codes under focused codes 'headings' for categorisation on separate spreadsheet within same Excel analysis document. Transfer codes onto interview transcript.
7. Create mind map of focused codes occurring within each interview. Consider which codes could be grouped (i.e., theoretical codes).
8. Create mind map for all interviews: continuously add focused codes from each interview to this mind map to identify common codes occurring across all interviews.
9. Frequently occurring/significant initial codes: record these in separate column on Excel document. These should map onto focused/theoretical codes for theory development
10. Repeat steps 1-9 for each interview. In addition to memo writing to support process.
11. Interview schedule adjustment: keep notes of rationale for changes based on emerging theory and areas of interest to probe.
12. Once interviews and coding are complete go back to examine focused codes more in-depth (internal themes and significant codes) to support theory development.
13. Theory development: based upon multiple levels of coding (initial, focused and theoretical). Identify quotes required to support lines of inquiry or analysis. For write up and theory development inspect:
    - Excel document (coding analysis) + frequently occurring initial codes + focused codes + significant quotes lists
    - Mindmap groupings (individual and all interview documents) + grouping of significant focused codes -> into theoretical codes/categories document
    - List of 'significant focused code internal themes'
    - Interview memos
    - Model development discussions memos
    - Grouped hypotheses across interviews document

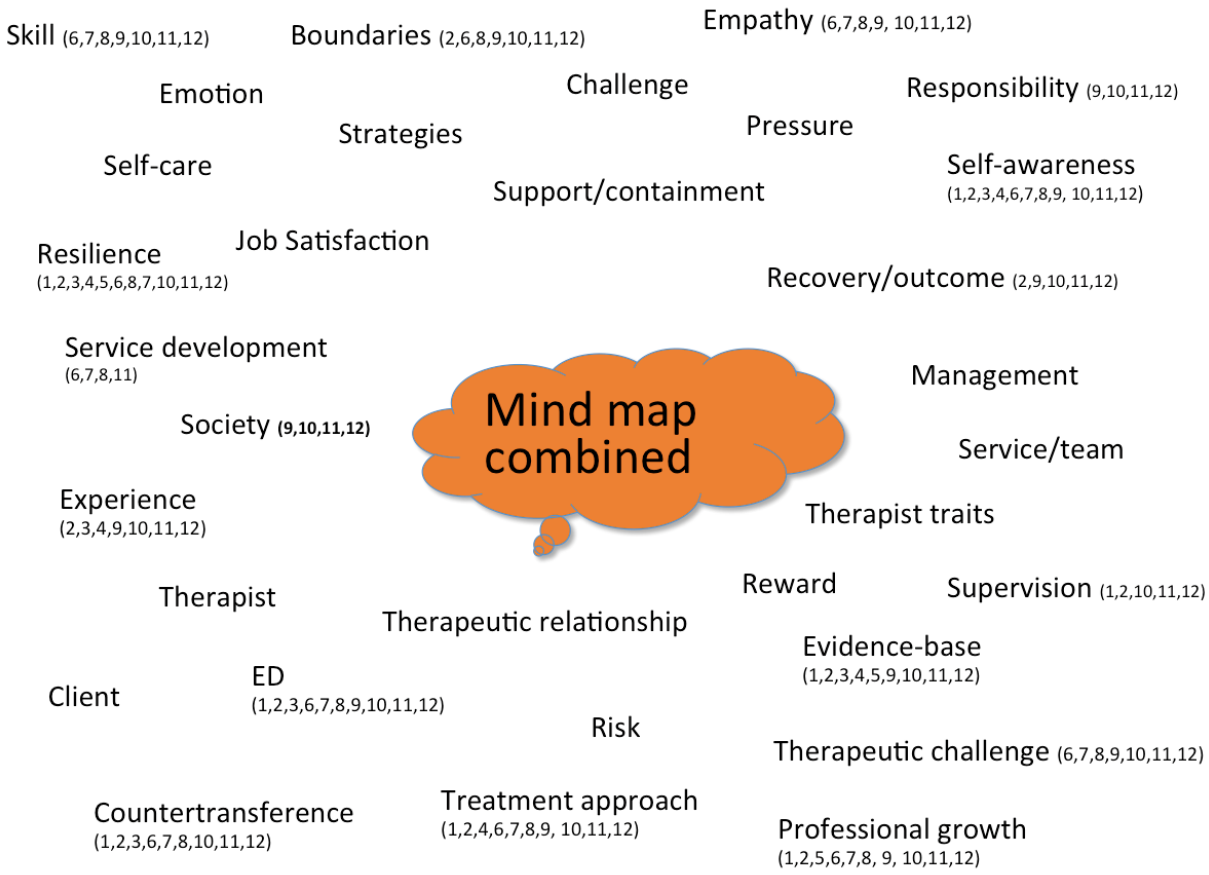
Appendix P: Transcript with example of coding process

Transcript	Initial Code	Focused Codes	Theoretical Category
Ok. Can you talk a bit about how you are able to manage emotional challenges that the job brings? So you spoke about sometimes feeling quite hopeless, particularly around medical risk…how are you able to manage this?			
So I think for me the two factors are having a supportive team, so that you can quite practically share the risk but also emotionally, feel supported and then…erm, what was the other factor that was just really clear in my head? And it's just completely gone…yeah, that was it…having a framework, as a psychologist having, I suppose, a formulation in my head of a framework of understanding and then supervision is very much part of that so…erm…using my own supervision to think about that.	Valuing team support Risk shared with team Emotional containment by team Valuing formulation Valuing formulation Supervision used to seek clarity Supervision as valued	Service/team Risk Support and containment Therapeutic approach Strategies	Service-related factors Therapist Strategies
To reflect on that, yeah. Ok. Thank you. Ok, so coming towards to end now…what do you think to be the most rewarding part of you job? Working with this service…with this population?			
I think that there can be, and it is rare, [*laughs*] erm…I have had, I've had people where, it's probably the nearest thing that I have seen to cure, in a way, erm…because where someone does, maybe, something has happened in their lives, so they've had a fairly, healthy-ish relationship with themselves and with others and their life was ok in most areas and then something has happened and then this was their way of coping with the something…I've seen it when we've got...you know intervening relatively early,	Acknowledging rewards Recovery as rare Client achieving recovery Client trauma – catastrophic event Client identity Client change in functioning ED as reaction to life event Early intervention approach	Reward Outcome/Recovery Client Therapeutic approach	Job Satisfaction Unique treatment factors

you know, and someone is just on the cusp of anorexia and they have *just* tipped into that, but they are not completely entrenched in it. You know…I've worked with a couple of people who have completely turned it around and they have got back into what they really wanted to do. In one case, you know, she started going out and meeting people again, she formed a new relationship, she's bought a house with this guy. Her life has completely turned around and think that that is unusual to see, erm… in a lot of areas of secondary mental health and it is unusual to see it too…you can see it here and I think, again, because the solution is very simple, that if people are able to start to do it there can be quite incredible results…quite relatively soon.	Being on cusp of AN Entrenchment with ED (AN) Recovery as possible Getting life back Client embracing recovery Recovery and resuming functioning Recovery in secondary care tough Treatment as "simple" Holding hope for recovery Recovery as possible	Therapeutic Challenge Experience Skill Outcomes/recovery Therapeutic approach Strategy	Challenge Therapist factors Job Satisfaction Therapist Strategies

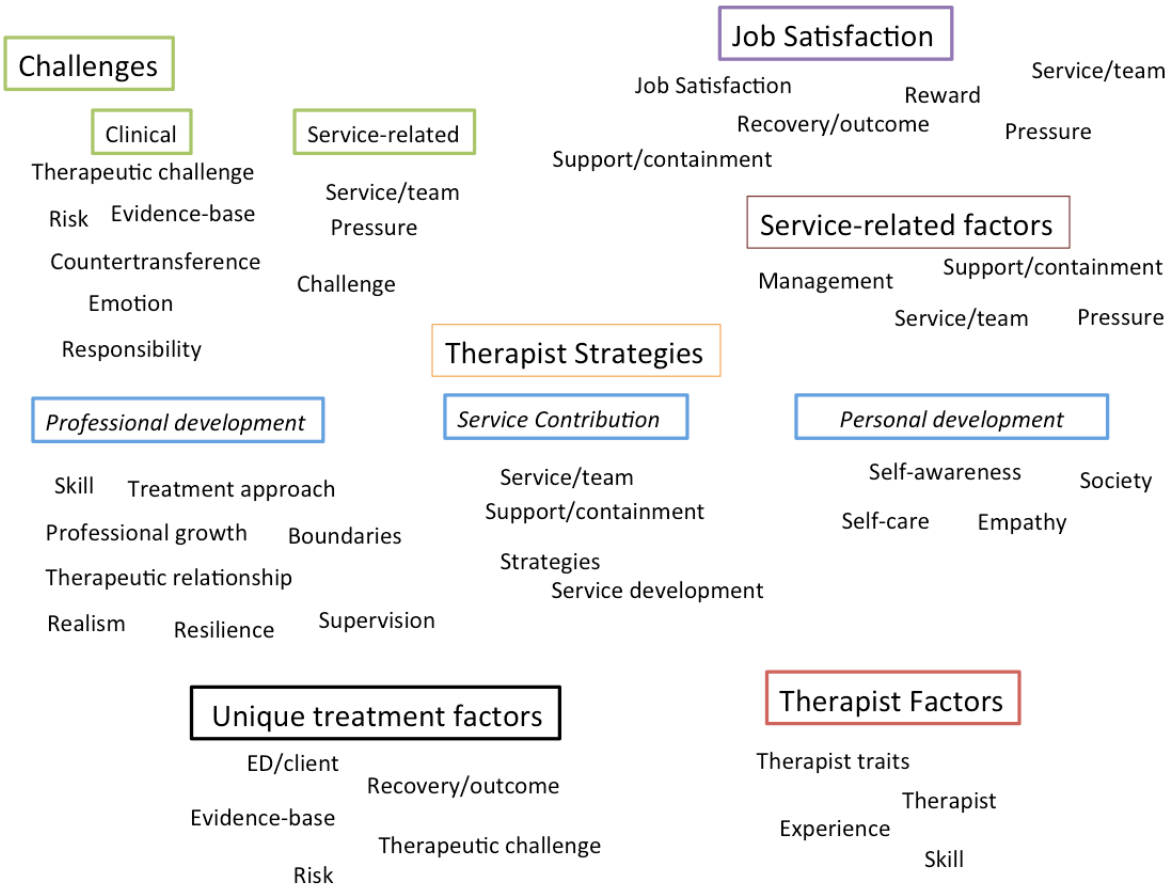
Appendix Q: Coding tree mind map, focused code and theoretical code grouping illustration and coding example

Coding Tree of Focused Codes



Less frequently occurring focused codes (24 codes):
Parents, Self-critical, Psychiatry, Anxiety, Anorexia, Proactive approach, Hierarchy, Medics, Self-doubt, Professional relationships, Isolation, Reaction to interview, Confidence, Defensive, Perfectionism, Non-ED colleagues, Mental health, Dual role, Male, Family, Autonomy, Professional Relationships, Professionalism.

Focused and Theoretical Categories Grouping Illustration



Coding Example

Theoretical code	Focused code	Initial code
Challenge	Evidence-base	Evidence-base (poor)
		NICE guidance
		Questioning self
	Therapeutic challenge	ED as challenging
		Client being entrenched
		Pushing enough
	Countertransference/emotion	Despairing for client
		Hopelessness
		Stuckness
	Risk	Challenge (medical management)
		Risk as uncertain
		Experiencing angst
	Pressure	Commissioning standards
		Waiting times
	Responsibility	Therapist feeling responsible
		Holding realistic mind set
		Pressure (feeling responsible)
	Service/Team	Team (communication difficulties)
		Team boundaries (mixed)
		Lacking resources