

The process of building resilience in the IAPT Psychological Wellbeing Practitioner role: A qualitative grounded theory study

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Thesis Portfolio Abstract

Background

A range of competing demands places psychological therapists at risk of developing burnout, which impacts on them personally and professionally. Research has highlighted that resilience can act as a protective factor against the development of therapist burnout. Currently, however, there is limited understanding of the resilience-building processes in psychological therapists.

Method

This thesis portfolio contains a systematic review and an empirical paper. The systematic review synthesised and appraised qualitative literature exploring the experiences and impact of therapist burnout, as well as their coping strategies. The empirical paper developed a qualitative grounded theory of the resilience-building process in Psychological Wellbeing Practitioners (PWPs) working in the Increasing Access to Psychological Therapy (IAPT) programme.

Results

The findings of the systematic review showed that burnout can have a severe impact on therapists' personal and professional lives, blurring the boundaries between these two areas. Systemic and organisational factors were identified as the most significant contributing factors to therapist burnout. Therapists engage in individual and systemic strategies to prevent and reduce burnout. The empirical paper found that PWPs develop resilience through the connection with their values and appraising work-related challenges in relation to those values, promoting the use of effective coping strategies.

Conclusion

The systematic review draws attention to how therapists experience burnout and the wide range of influences that affect its development and management. The empirical paper puts emphasis on the values-based appraisal of work adversity and the use of effective coping strategies to enhance

resilience. Overall, this thesis stresses the need to capture the complex nature of burnout and resilience, and the processes underlying these constructs. Further research is needed to further explore these areas and develop a deeper understanding of these processes.

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Chapter 1.

Introduction Chapter

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The constructs of burnout and resilience, as well as their complex and evolving definitions, emerged in the seventies with the work of pioneer authors and their studies (Freudenberger, 1974; Garmezy, 1970). The term burnout was coined to reflect the physical and emotional difficulties, such as fatigue, emotional disconnection and insecurity, experienced by healthcare staff (Freudenberger, 1974). Over the years, this definition further developed to encompass the high levels of stress and decreased personal satisfaction that people can experience, in addition to their emotional difficulties (Maslach, 1982). A more recent definition included in the International Classification of Disease, 11th Revision, stressed three core dimensions of burnout as a syndrome stemming from chronic work-related stress: feelings of energy exhaustion or depletion; increased psychological detachment, negativism or cynicism about one's occupation; and decreased work efficacy (World Health Organisation, 2018).

Research on resilience started with work carried out by Garmezy (1970), which focussed on understanding premorbid levels of professional, social and interpersonal competence in people with a diagnosis of schizophrenia. Similarly, studies on children of mothers with a diagnosis of schizophrenia began to emerge at the same time, investigating children's ability to thrive in society despite their high-risk status (Garmezy, 1974). Werner's pioneering studies on 'invincible' children, who experienced family and environmental risk factors early in life (Werner, 1985; Werner & Smith, 1982), prompted research to take into account wider socio-economic, community and environmental dynamics when studying resilience (Luthar et al., 2000). More recently, research has focused on the wider psychological, interpersonal, social and environmental processes that contribute to the development of resilience (Cicchetti, 2010; Ungar, 2011). Similarly, the American Psychological Association (APA) defined resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress" (APA, 2014, p. 1), emphasising the ability to 'bounce back' from challenging experiences.

In recent years, research has increasingly investigated the association between burnout and resilience in the healthcare workforce, highlighting the role of resilience as a protective factor against burnout (Edward, 2005; Manzano García & Ayala Calvo, 2012). The conceptual link between these two constructs has been explored in several studies involving various healthcare professionals. Numerous studies involving physicians (Taku, 2014), nurses (Kutlurkan et al., 2016; Manzano García & Ayala Calvo, 2012), and ambulance staff (Treglown et al., 2016) found that higher levels of resilience were associated with lower levels of burnout, measured using self-report scales and questionnaires.

Given the frequent exposure to highly emotive and distressing narratives and the intrinsic sense of responsibility for their clients' emotional wellbeing, psychological therapists are particularly vulnerable to developing burnout (Rupert et al., 2015; Simpson et al., 2019). Understanding how therapists cope with work-related difficulties is therefore crucial to maintaining their wellbeing and work effectiveness. Clark (2009) explored resilience in family therapists using a grounded theory methodology and theorised that the integration of self and practice, seen as an attempt to be true to themselves while progressing professionally, was a key process in generating therapist resilience. The study highlighted that relying on peer support, enjoying their day-to-day work and finding meaning in their profession were among the factors that contributed to developing resilience in family therapists. Jones and Thompson (2017), in their qualitative interpretative phenomenological analysis study exploring trainee clinical psychologists' experience of resilience, identified that work-life balance, being supported by friends and family, job satisfaction and peer support all contributed to building resilience. Hou & Skovholt (2020), in a qualitative study exploring the characteristics that sustain therapists' resilience, found that highly resilient therapists develop strong interpersonal relationships, actively engage with their core beliefs framework and have a desire to learn and grow.

These studies highlighted the importance of resilience in understanding how physical and mental health care professionals make sense of, and overcome, occupational challenges, which has led to the development of various conceptualisations of resilience in the workplace. Dunn et al. (2008) theorised that medical students have an internal reservoir in which personality traits, temperament and coping styles all play a part to help them to maintain their wellbeing. Depleting factors such as stress, internal emotional conflicts, and the imbalance between time and energy demands can lead to burnout, while replenishing factors such as strong professional and personal support networks, social and healthy activities, effective guidance and mentorship, and the desire to be intellectually stimulated can lead to resilience (Dunn et al., 2008). Van Breda (2011) conceptualised a workplace resilience model for social workers in which risk factors, including internal and external stressors, increase the likelihood of work-related stress, while protective factors, including support networks inside and outside the workplace, the ability to solve problems effectively, positively appraising work-related challenges, and balancing personal and professional life minimise occupational stress (Van Breda, 2011).

The relationship between staff wellbeing and the quality of the care they provide has therefore become a priority for physical and mental health services, as acknowledged by the National Health Service (NHS) in England (Paparella, 2015). Representative bodies such as the British Psychological Society (BPS) and the American Psychological Association have also warned about the clinical and ethical implications of therapist burnout, recommending the implementation of self-care and consideration as to how psychologists and psychological therapists can preserve their own wellbeing (APA, 2017; BPS, 2018). It is crucial to develop a more comprehensive understanding of therapist burnout and how they develop resilience in the face of adversity.

Summary of Thesis Portfolio

The aim of this thesis is to explore the experiences and processes related to therapist burnout and resilience. Chapter 2 presents a qualitative systematic review of the literature on burnout in

psychological therapists. It focusses on therapist experiences of burnout, and the personal and professional strategies employed to manage and adapt to burnout. Chapter 3 conceptually links the systematic review and empirical paper, touching on the overlapping implications between burnout and resilience in psychological practitioners. Chapter 4 includes an empirical study that explores the resilience-building process in the Psychological Wellbeing Practitioner (PWP) role working in Increasing Access to Psychological Therapies (IAPT) services. Finally, Chapter 5 connects and contextualises the findings of the systematic review and empirical paper, and provides a critical and reflective account of the process of carrying out research both in relation to the systematic review and empirical study.

Chapter 2.

Systematic Review

Psychological Therapists' Experiences of Burnout: A Qualitative Systematic Review and Narrative Synthesis

Prepared for Submission to the Mental Health & Prevention journal (Appendix A)

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Psychological Therapists' Experiences of Burnout: A Qualitative Systematic Review and Narrative Synthesis

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Abstract

Purpose: Research has highlighted that psychological therapists are vulnerable to developing burnout due to the frequent exposure to emotive narratives of distress. A number of quantitative systematic reviews have provided an overview of the risk and protective factors associated with therapist burnout. To date, however, no qualitative systematic reviews on therapist burnout have been carried out. This systematic review aimed to explore the experiences and impact of burnout in psychological therapists, and the strategies they use to adapt to it.

Design: Systematic searches of three electronic databases (CINHAL EBSCO, Medline EBSCO and PsycINFO EBSCO) were conducted following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA). Papers were screened at title and abstract and full-text review stages. The Critical Appraisal Skills Programme (CASP) qualitative checklist was used to evaluate the methodological quality of the included studies.

Results: Nine peer-reviewed papers met the eligibility criteria. The methodological appraisal highlighted some strengths and weaknesses of this body of literature. The findings stressed the severe professional and personal impact that burnout can have on therapists. Systemic and organisational factors were described as the most significant contributing factors to burnout. Self-care and wellbeing activities, effective supervision, peer support, and finding meaning in their work were the most helpful strategies employed.

Conclusions: More research in this area is needed to expand on these findings and develop a greater understanding of the experiences and management of burnout in psychological therapists.

Theoretical implications and clinical recommendations related to the findings are also discussed.

Keywords: burnout, stress, mental health, psychological therapists, psychologists, systematic review

Declaration of Interests: none.

Introduction

The term burnout was introduced by Freudenberger (1974), who described it as a process of physical and emotional exhaustion, fatigue, detachment and self-doubt that people who work in caring and supporting roles can experience (Freudenberger, 1974). Maslach's definition of burnout (1982) stresses the enduring nature of this type of stress, involving depersonalisation, emotional exhaustion and a reduced sense of personal accomplishment (Maslach, 1982). Burnout has been associated with a number of conceptually similar constructs, such as compassion fatigue (Bhutani et al., 2012), occupational stress (Simionato & Simpson, 2018), vicarious trauma and secondary traumatic stress (Nolte et al., 2017). While it is easier to differentiate burnout from vicarious trauma and secondary traumatic stress, given that these two concepts both entail exposure to traumatic content (Rauvola et al., 2019), the distinction between compassion fatigue and burnout is less clear-cut as they share important conceptual elements, such as emotional exhaustion, fatigue and disengagement (Nolte et al., 2017). Similarly, occupational stress and burnout have both been associated with psychological suffering and impairment due to work pressures and demands, thus maintaining a stronger conceptual link (Simionato & Simpson, 2018).

Burnout has been identified as a significant work-related challenge for psychologists and psychological therapists (McCormack et al., 2018; Simionato & Simpson, 2018) and, more generally, in mental health settings, with between 21% and 67% of services reporting high levels (Morse et al., 2012). The frequent exposure to narratives of distress, loss and trauma makes psychological therapists particularly vulnerable to developing occupational stress and burnout (Bears et al., 2013; Simionato et al., 2019). Studies investigating the prevalence of burnout in psychotherapists show prevalence rates that range from 2-6% (Farber, 1990) to over 50% (Simionato & Simpson, 2018). Codes of conduct and professional guidelines for psychologists and psychological therapists, such as those published by the American Psychological Association (APA) and The British Psychological Society (BPS), have highlighted the risks of burnout and its

potential impact on clinical work, thus recommending to also consider it from an ethical perspective (APA, 2017; BPS, 2018).

Research has highlighted that burnt-out professionals are less likely to adequately provide empathy and emotional support due to engaging in defence mechanisms that preserve their emotional capacity, which in turn has a detrimental impact on clients' wellbeing and recovery (Bearse et al., 2013; Connor et al., 2018; Lee et al., 2011). Burnout in psychologists and psychological therapists has also been linked to reduced productivity, increased absenteeism, turnover, poorer personal efficacy and a higher risk of developing mental health difficulties, such as depression (Simionato et al., 2019; World Health Organisation, 2018). A systematic review on the prevalence and causes of burnout in applied psychologists, which included 29 papers, found that emotional exhaustion was the most commonly cited component of burnout, with work setting, workload and time pressure being the most significant job factors leading to burnout. Older psychologists were less likely to experience burnout as they had learnt how to preserve their emotional energy over time (McCormack et al., 2018). Another systematic review on antecedents and consequences of burnout in psychotherapists, comprising 17 studies, found that therapist over-involvement was the most significant variable to correlate with emotional exhaustion, while having more control over their work was the most significant factor to negatively correlate with depersonalisation (Lee et al., 2011). Another recent systematic review (Simionato & Simpson, 2018) on the risk factors associated with burnout in psychotherapists, including 40 studies, found that younger age, less professional experience and therapist over-involvement in their clients' problems were the most common factors associated with burnout.

These systematic reviews on burnout in psychological therapists have only included quantitative studies and methodologies with little attention to how psychologists and psychological therapists experience burnout within their professional roles. To date, there have been no qualitative systematic reviews or meta-syntheses on burnout in psychological therapists. The aim of this

qualitative systematic review is therefore to explore therapist burnout from a broader, qualitative perspective, adopting a critical realist stance. A systematic review and synthesis of qualitative studies of how therapists experience burnout could provide further insight into the difficulties and challenges they experience, uncovering their professional and personal coping strategies, which could inform service training and policies aimed at preventing burnout and promoting resilience and wellbeing.

Research Questions

Primary research question: ‘How do psychological therapists subjectively experience burnout?’

Secondary research question: ‘What are the professional and personal strategies that can help to prevent and reduce burnout in psychological therapists?’

Methods

The systematic review was completed in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009). A protocol for the systematic review was registered on the PROSPERO (International Prospective Register of Systematic Reviews) database, outlining the inclusion and exclusion criteria, the search and screening strategies, and the methodological approach (reference: CRD42021247832).

Given the high heterogeneity of the samples, settings, contexts and methodologies of the included studies, results were synthesised using a narrative synthesis approach (Popay et al., 2006).

Data Sources and Search Strategy

The available literature was reviewed by electronically searching three databases, CINHAL EBSCO, Medline EBSCO and PsycINFO EBSCO, and hand-searching the reference lists of the included studies. Boolean operators ‘and’ and ‘or’, wildcards and truncation symbols, such as ‘*’, were used to combine search terms effectively and maximise search results (see Table 2.1).

Controlled vocabulary and keyword functions were also used, where possible. In order to identify all relevant studies, no date restrictions for the searches were applied.

Eligibility Criteria

Similarly to other systematic reviews on burnout in psychotherapists (Simionato & Simpson, 2018), the term ‘psychological therapist’ was employed broadly to encompass both psychologists and psychotherapists. This review included studies on therapist burnout and related constructs, including occupational stress, compassion fatigue and emotional exhaustion. Studies on secondary traumatic stress and vicarious trauma were not included as they focus on conceptually different constructs. Similarly, studies on therapist resilience were also excluded from this review.

Inclusion criteria included: peer-reviewed studies (i.e., dissertations were excluded), studies published in the English language, studies focussing on the experience of burnout and related concepts (i.e., occupational stress, compassion fatigue, emotional exhaustion), studies focussing entirely on psychological therapists delivering therapy (i.e., studies including nurses, doctors, social workers, etc. were excluded).

The following exclusion criteria were applied: studies including art and music therapists as participants, studies including sport psychologists as participants, studies including counsellors as the only participants (i.e., without any other psychological therapists), studies including unqualified therapists (e.g., trainees, students, etc.), studies classed as secondary research (e.g., systematic and literature reviews), studies using quantitative and mixed-method designs, single case-studies, commentaries, personal reviews or reflections, books, or book reviews.

Studies that included art and music therapists, sport psychologists, counsellors and unqualified therapists as the only participants were excluded. This decision was guided by existing reviews on therapist burnout (Connor et al., 2018; McCormack et al., 2018; Simionato & Simpson,

2018) and professional classifications of psychological professions, such as the ones adopted by the Psychological Professions Network (NHS England, 2021).

Table 2.1

Search Terms

Therapist, therapy or impact on therapist terms	Participant, participant experiences or impact on client terms	Methodology terms
therapist* OR psychotherapist* OR psychologist*	burnout OR 'burn out' OR burn-out OR stress OR 'occupational stress' OR 'compassion fatigue' OR 'emotional exhaustion'	'qualitative research' OR 'qualitative' OR 'grounded theory' OR 'narrative' OR 'Interpretative phenomenological analysis' OR 'thematic analysis' OR 'discourse analysis'

Screening and Selection of Studies

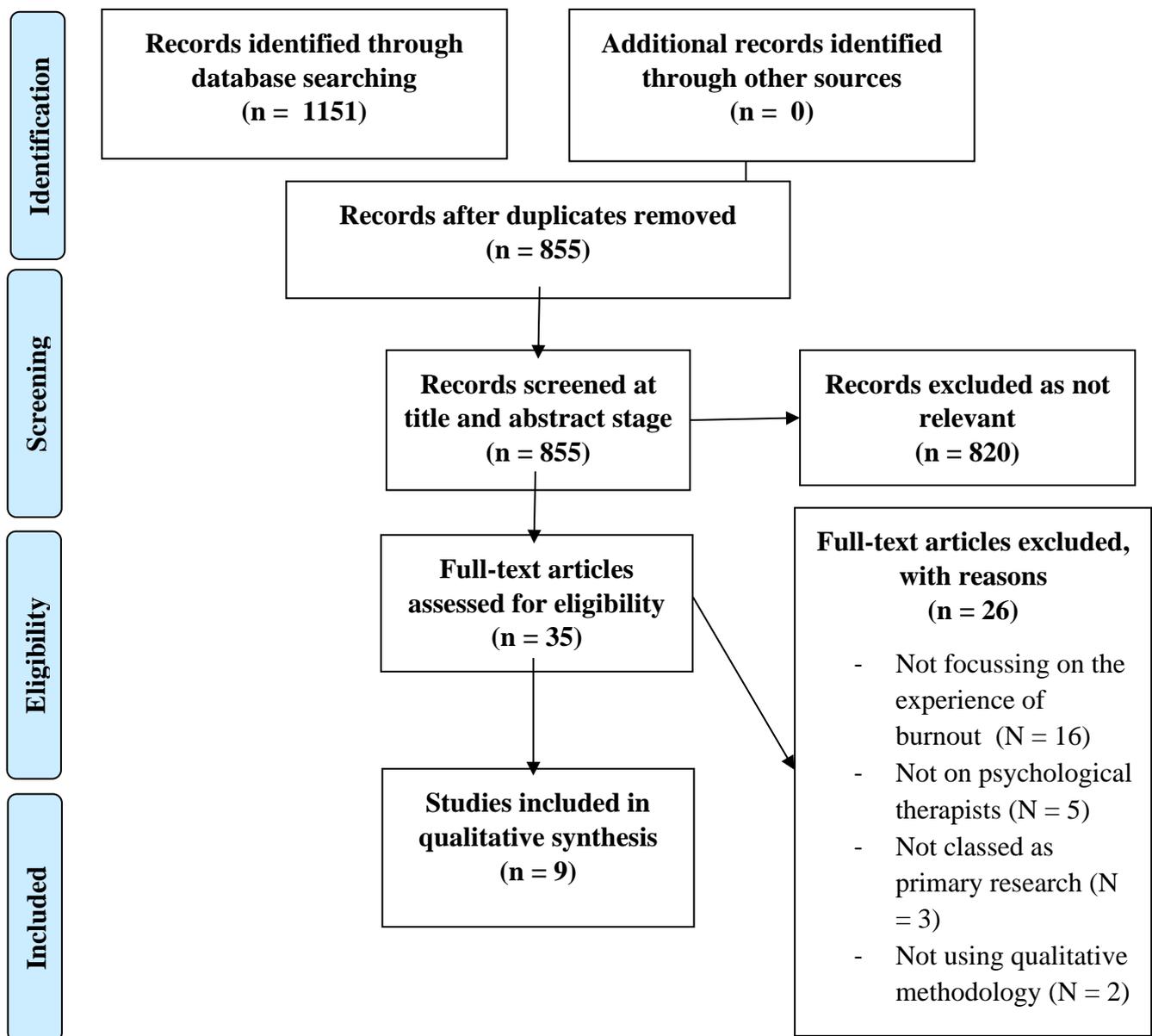
Final electronic searches using the three databases were conducted on 27 April 2021 and generated a total of 1,151 results, with the PsycINFO database yielding 667 results, and the CINHAL and Medline databases yielding 216 and 268 results, respectively. After removing duplicates, 885 studies were retained (see Figure 1) and screened by the first author (M.V.). Studies were initially screened at title and abstract stage. Following the title and abstract screening, 35 articles were retained and screened at full-text stage. This led to a further reduction and nine studies were subsequently included in the review, having met the inclusion criteria. Hand-searching the reference lists of the included studies did not generate any further results.

Random samples of 25% of papers at both title and abstract (N=214) and full-text (N=9) review stages were screened by an independent reviewer, who was not part of the research team. The percentage agreements with the first author (M.V.) were high, 99% (N=212) at title and

abstract screening stage and 89% (N=8) at full-article review stage. Disagreements between the first author (M.V.) and the independent reviewer were resolved by consensus, consulting and referencing the eligibility criteria. In addition, the three authors of the review met regularly to discuss the screening process and any related decisions to ensure consistency and transparency.

Figure 2.1

PRISMA Flow Diagram showing the Screening and Selection Process



Data Analysis

Due to the methodological heterogeneity of the qualitative studies included in this review, results were synthesised using a narrative synthesis approach (Popay et al., 2006). Narrative synthesis is a commonly used synthesis approach for systematic reviews. This approach involved developing an interpretation of the review's findings that can contribute to assessing their applicability and relevance in the context of psychological therapists' experiences of burnout. In order to organise the findings from the included studies, a preliminary analysis was carried out. This involved reading and immersing in the results and discussion sections of the included papers to familiarise with the data and develop an initial description of the findings. Subsequently, the characteristics of the findings from the included studies were explored through the use of grouping, clustering and tabulation. Finally, a critical evaluation of the strength of the synthesis was provided (Popay et al., 2006).

Results

Data Extraction Outcome

Nine papers met the inclusion criteria and were therefore included in the review. Three main domains were identified, which were used to cluster the findings based on their research questions and the relevance of their data for the current review: the experience and impact of burnout, the factors contributing to burnout, and the strategies that help to prevent and reduce burnout.

Key information from the included studies was extracted using a data extraction form, comprising study aims and research questions, sample size and characteristics, study setting and context, recruitment and data collection techniques, and analytical methodology (see Table 2.2). A summary of the key findings was also provided (Table 2.3).

Table 2.2*Study Characteristics*

Author(s), Date and Country	Aims	Sample Size and Characteristics	Setting and Context	Recruitment and Data Collection Techniques	Data Analysis Methodology
Clarke et al. (2020), Australia	To explore the perceived effects of emotional labour in psychologists providing individual psychotherapy. To explore whether there are differences in the perceived consequences of emotional labour between psychologists with varying levels of experience	24 psychologists with varying training backgrounds (e.g., clinical psychology, counselling psychology, organisational psychology) working primarily in the provision of individual psychotherapy	Government and non-government agencies, independent practice or a mix of these three in outpatient and community settings in Australia	Semi-structured interviews (purposive and snowball recruitment techniques)	Thematic analysis and theme frequency analysis
Cramond et al. (2020), United Kingdom	To explore the experiences of clinical psychologists working in palliative care services for adults with cancer, and to gain an understanding of the impact of the work on their self and how they manage this	12 clinical psychologists working in palliative care	Various palliative care settings in the UK	Semi-structured interviews (purposive recruitment techniques)	Interpretive phenomenological analysis
Hammond et al. (2018), Australia	To explore clinical psychologists' experiences of burnout	6 privately practising and solo-employed clinical psychologists	Private sector in Australia	Semi-structured interviews (purposive recruitment techniques)	Thematic analysis
Norrman Harling et al. (2020), Sweden	To explore psychologists' experiences of compassion fatigue and identify individual, interpersonal and organisational factors perceived as protecting or contributing, to identify successful coping strategies used by psychologists	8 psychologists working in publicly funded organisations	Both general and specialised publicly funded care settings in Sweden	Semi-structured interviews (purposive recruitment techniques)	Thematic analysis

Papadomarkaki & Lewis (2008), United Kingdom	To capture, explore and describe the way counselling psychologists experience work-related stress, focussing on their professional behaviour and the impact on their personal lives and ways of coping with stress	6 counselling psychologists working in different mental health care settings	Different mental health care settings, including NHS services and private practice in the UK	Semi-structured interviews (did not specify recruitment techniques)	Thematic analysis informed by interpretive phenomenological analysis
Reitano (2021), United Kingdom	To explore how psychological therapists perceive occupational stress and team environment in oncology settings, including the specific aspects they find most challenging and what helps them to promote and maintain resilience	6 participants (3 counsellors, 2 psychotherapists and a counselling psychologist) working in oncology settings	Oncology settings, including an acute hospital and a cancer care charity in the UK	Semi-structured interviews (purposive recruitment techniques)	Interpretive phenomenological analysis
Sciberras & Pilkington (2018), Malta	To explore the issues faced by psychologists working in MDT's in public mental health services, where the leading treatment philosophy is based on the medical model, to explore how psychologists cope with these issues and what would help them to cope better	7 psychologists working in public mental health services	Public mental health services in Malta	Semi-structured interviews (purposive recruitment techniques)	Interpretive phenomenological analysis
Sim et al. (2016), United States	To examine thriving, burnout and coping strategies (and what contributes to these) of early and later career psychologists working at college and university counselling centres in the US, to explore whether early and later career psychologists differ in terms of thriving, burnout and coping strategies	14 staff psychologists working at college and university counselling centres	Different college and university counselling centres located in the US	Semi-structured interviews (snowball recruitment techniques)	Consensual qualitative research

Turnbull & Rhodes (2019), Australia	To explore psychologists' lived experience in relation to burnout, recovery and wellbeing	17 psychologists (2 groups, 10 participants self-identified as having experienced burnout, 7 participants self-identified as not having experienced burnout) working across a wide variety of services	Various services, including child protection, private and public hospitals, non-profit organisations and independent practice in Australia	Semi-structured interviews (snowball recruitment techniques)	Narrative inquiry
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Table 2.3*Summary of Results of Included Studies*

Study	Main Findings	Additional Notes related to Findings
Clarke et al. (2020), Australia	3 main themes: <ul style="list-style-type: none"> - Personal growth - Feeling depleted and exhausted - Craving space free from people and work-related emotion 	<ul style="list-style-type: none"> - Emotion management at work leading to personal growth through emotional expansion and awareness; being on a journey of self-discovery, self-learning and self-reflection; therapists reporting an increased understanding of their emotional experiences and interpersonal interactions, and more able to empathise with clients - Managing emotions linked to burnout, feeling depleted, exhausted and fatigued; ‘being there but not being there’, experiencing compassion fatigue as inability to feel the emotion for the patient; feeling depleted of emotional resources, unable to engage well interpersonally; reduced emotional availability; reduced capacity to provide emotional support due to emotion management with clients; becoming more intolerant and frustrated a with family and friends; dissatisfaction and frustration with personal interactions perceived as trivial and lacking depth - Need for space from other relationships, reduced stimulation, tendency to avoid work-related emotions; not seeking social contact and wanting to spend time alone in less stimulating environments; less engagement in emotionally taxing relationships and leisure activities; avoiding content that is likely to re-evoked negative work-related emotional states
Cramond et al. (2020), United Kingdom	3 main themes: <ul style="list-style-type: none"> - Commitment: ‘More draining but also more rewarding.’ - Existential impact on the self: ‘You can’t walk through water without getting wet.’ - The Oracle: ‘[The team] see me as some kind of emotional robot who can kind of manage it all.’ 	<ul style="list-style-type: none"> - Experience of working in palliative care a privilege, rewarding, making a difference. Knowing that fixing (people) is not needed, just sitting with people’s difficulties. Threat of patient death leads to uncertainty in the therapeutic relationship. Pressure of organisational changes, ‘trying to do more for less’, managerial tasks most stressful ones - Therapists affected by work, being unable to separate themselves from their patients (‘You’re just like me’); awaiting sadness (patient death); more awareness of their own mortality; compassion fatigue (dealing with deaths and grief) experienced as inability to listen to patients, rumination and insomnia (‘I just didn’t want to hear it, any more bad stuff’), avoidance of emotionally challenging sessions - Clinical psychologists’ expectations to be infallible experts on emotions and distress, and able to contain other people’s emotions; awareness of emotional impact on self even when able to manage distress experienced by other people; difficulty containing own emotions and need to share this with their team and managers (‘I’m a human being too’)

<p>Hammond et al. (2018), Australia</p>	<p>5 main themes:</p> <ul style="list-style-type: none"> - Demanding aspects of working as a clinical psychologist - Symptoms of burnout - Precursors of burnout - Protective factors of burnout - Barriers to overcoming burnout 	<ul style="list-style-type: none"> - Therapists unaware and unequipped to face burnout - Physical, emotional and psychological effects of burnout (including ‘enduring’) - Physical and mental precursors; work-related and personal; transference - Knowledge, experience and trusting long-term relationships - Prioritising clients’ expectations and needs over their own; financial costs in private practice; lack of knowledge and education about self-care; time constraints
<p>Norrman Harling et al. (2020), Sweden</p>	<p>5 main themes:</p> <ul style="list-style-type: none"> - Mission impossible - Emotional strain - Consequences - Interpersonal factors - Shielding and strengthening factors 	<ul style="list-style-type: none"> - Wide range of different tasks (e.g., excessive admin, coordination), clinical complexity and high caseloads; dissatisfaction with framework and policies - ‘Jesus complex’, being always expected to show compassion; forcing compassion; ethical stress and lack of resources - Annoyance, categorical thinking, numbness and isolation as signs of compassion fatigue - Support from colleagues; amplification of each other’s complaints through talking; role of leadership; friends and family as a source of support and distraction; personal relationships exacerbating difficulties - Noticing own struggles, well-being strategies; being realistic, lowering expectations and taking control of the situation; implementing self-care; job satisfaction and professional development
<p>Papadomarkaki & Lewis (2008), United Kingdom</p>	<p>4 main themes:</p> <ul style="list-style-type: none"> - Uncertainty - Relationship with significant others - ‘Being me’ - Criticism of professional identity 	<ul style="list-style-type: none"> - Organisational changes experienced as stressful, threatening psychologists’ identity; uncertainty about role and personal conflicts with the medical model; need to be recognised by the employer; experience of time pressures, working long hours; complex clients leaving therapists with difficult feelings, doubting own work; stress from working solo with high-risk clients - Work having a significant impact on therapists’ relationships with family and friends (being available and supportive, feeling depleted, and having distorted roles and expectations) - Ability to be themselves, working in line with own values; importance of good supervision providing reassurance and validation; supportive families that listen to their needs; peer support as an important factor to increase self-esteem and reduce work stress; need to feel part of a community, which alleviates isolation and uncertainty - Concerns about the way psychologists are viewed in their departments, experiencing criticism, derogatory views and lack of recognition

<p>Reitano (2021), United Kingdom</p>	<p>3 main themes:</p> <ul style="list-style-type: none"> - Lack of understanding of the therapist's role - The value of team support - Self-care and self-awareness 	<ul style="list-style-type: none"> - Lack of understanding of therapist's role. Challenges faced in the medical model, lack of collaborative approach. Organisational pressures and unrealistic expectations as the greatest source of occupational stress. Expectation to contain not only patients' distress but also other professionals' stress. Need to challenge other professionals to work ethically. Pressures from increased workload, lack of resources, operational rules, long waiting lists, little time to prepare in between sessions and miscommunication with other professionals. Occupational stress from focus on targets and diagnoses, rather than clients' needs - Team support as the most valuable resource to prevent and reduce occupational stress. Building a positive team culture to help therapists feel less isolated and exposed. Importance of being able to talk freely about own vulnerabilities. Identifying common values at work. Balancing power dynamics in the team and build collaborative practice. Being committed to doing their best for patients; fostering a flexible and caring approach to practice; offering and receiving support when needed, staying connected with peers - Building resilience key to reducing occupational stress and preventing burnout; importance of self-awareness, self-care, reflection and self-compassion; keeping boundaries in place and being mindful of own limits (e.g., 'not having to fix people'). Accepting one's own vulnerability, developing ability to recognise and accept own difficulties. Clinical supervision and promoting therapists' wellbeing outside of work to prevent stress (e.g., mindfulness and relaxation)
<p>Sciberras & Pilkington (2018), Malta</p>	<p>3 main themes (one was not discussed):</p> <ul style="list-style-type: none"> - Client-work as a source of satisfaction and a source of stress - The psychologist in the context of the multidisciplinary team - Focus on the self - Other systemic problems (theme not discussed) 	<ul style="list-style-type: none"> - Therapeutic work as main source of satisfaction; seeing improvements in patients' quality of life, feeling appreciated and seeing work as a learning experience; negative emotions arising from working with patients, particularly complex mental health problems and suicidal ideation; impact on therapists' personal lives and experiences; lack of training to work with complex presentations; therapists turning negativity into an enriching experience through reflection - Professional issues and negative emotions related to clinical approach in the MDT; perceiving mental health system as dominated by the medical model, rather than based on a collaborative approach; implied acceptance that the psychiatrist is the most important professional in the team; dominant values in the service clashing with therapists' beliefs; service not empowering patients choice and focus on symptoms; psychology perceived as an adjunct to the medical treatment and power dynamics leading to therapists' helplessness and powerlessness; therapists not feeling trusted and valued, feeling demotivated - Enthusiasm, motivation and positive feelings replaced by demotivation; leaving public services due to lack of trust, not feeling valued, lack of involvement in decision-making, divergence with the medical ideology; focussing exclusively on client-work to keep motivated and recover from burnout; self-awareness to manage negative environments, personal therapy, further education and outside supervision; support from colleagues; need to be accepted and share similar values at work

<p>Sim et al. (2016), United States</p>	<p>3 main domains:</p> <ul style="list-style-type: none"> - Thriving - Burnout - Coping 	<ul style="list-style-type: none"> - Recognition for achievement, clients improving and appreciating therapists' support, receiving praises from colleagues, support from colleagues and managers or directors, a sense that staff work well together, therapist autonomy, respect for limits at work and social activities with colleagues at work; supervising, training and mentoring new colleagues perceived as very satisfying; client improvement, opportunities to progress and develop further - Challenges related to therapists' work, such as non-clinical and crisis/clinical work, lead to burnout (e.g. 'not doing things as well as they like, feeling drained and exhausted, defeated, low satisfaction, staying afloat'); lack of time for clinical and crisis work contributing to burnout; imbalance between perceived demands and resources available; challenges related to professional relationships, including colleagues and peers; difficult relationships with supervisors and directors (e.g. 'not sleeping and functioning well, 'sense of anger and insecurity'), lack of mentors; personal difficulties, loneliness, sadness, isolation; health concerns, feeling depressed and worried about the future - Interpersonal and social support; self-care, engaging in wellbeing and leisure activities (e.g., exercise, mediation, yoga, healthy eating and hobbies); increasing self-awareness, adopting new perspectives and thinking about change; behavioural strategies such as setting boundaries and adjusting work schedule; use of personal therapy
<p>Turnbull & Rhodes (2019), Australia</p>	<p>3 main themes (from the burnout group):</p> <ul style="list-style-type: none"> - The experience of burnout - Attributions of burnout - Recovery 	<ul style="list-style-type: none"> - Sudden and long-term impact of burnout leading to being unable to work. Emotional exhaustion, depersonalisation and reduced professional efficacy. Burnout gradually building over time - Burnout explained as a combination of workplace, systemic and organisational factors, personal difficulties and the culture of psychology (stigma about own mental health difficulties) and training (lacking self-care and focus on therapist's values); difficulty establishing boundaries between work and professional life - Implementing personal and workplace self-care; finding meaning in everyday work; establishing boundaries and letting go of responsibility for clients' well-being outside of therapy; good quality supervision; seeking own therapy; recovery and self-care strategies leading to pre-burnout functioning; burnout as a process of personal change

Assessment of Methodological Quality

The Critical Appraisal Skills Programme (CASP) qualitative research checklist (Appendix B) was used by the first author (M.V.) to assess the methodological quality of the papers included in this systematic review (CASP, 2017). The checklist has 10 questions that consider research aims, methodology, research design, recruitment strategies, data collection methods, reflexivity of researchers, ethical issues, data analysis, presentation of findings and their contribution to the existing literature (CASP, 2017). As recommended by the Cochrane Group, the CASP checklist was used as a guiding framework to inform the synthesis and the findings (Long et al., 2020; Noyes et al., 2018), and was not used to exclude studies. The findings of the methodological appraisal were discussed with the second (J.O.) and third author (P.F.). Disagreements in interpretation were resolved through consultation.

Quality Assessment and Presentation of Findings

The CASP checklist was used to assess the methodological strengths and limitations of the included studies. The results of the critical appraisal process are summarised in Table 2.4. Based on the information provided in the published papers, Cramond et al. (2020) and Hammond et al. (2018) met all the criteria of the CASP checklist, while Papadomarkaki & Lewis (2008) and Sim et al. (2016) met the fewest criteria.

All included studies used an established qualitative methodology that was in line with the aims of the research. In terms of recruitment, most studies used either purposive recruitment techniques or snowball recruitment techniques. All the studies assessed in this review included at least some information about the inclusion and exclusion criteria, with the exception of one study (Papadomarkaki & Lewis, 2008). All the studies assessed in the review provided a rationale for using semi-structured interviews to collect data and included at least some detail about the content of the interview (e.g., interview schedule and questions). Only three studies specifically referenced the concept of saturation when explaining their data collection process (Clarke et al., 2020;

Cramond et al., 2020; Hammond et al., 2018). Five of the 9 studies (Clarke et al., 2020; Cramond et al., 2020; Hammond et al., 2018; Norrman Harling et al., 2020; Sciberras & Pilkington, 2018) referenced researcher reflexivity and its impact on the study. Three additional studies (Reitano, 2021; Sim et al., 2016; Turnbull & Rhodes, 2019) considered the position of the researcher to counter biases and assumptions but without referencing reflexivity. One study did not mention researcher reflexivity (Papadomarkaki & Lewis, 2008). Reflexive diaries, memos, regular reflection and involving additional researchers to review themes and interpretations were some of the most commonly used tools used to counter researcher bias and promote reflexivity.

All papers except two (Papadomarkaki & Lewis, 2008; Sim et al., 2016) explained how and where ethical approval for their research was granted. One study (Papadomarkaki & Lewis, 2008) omitted to describe how the research was explained to participants throughout recruitment. One study (Turnbull & Rhodes, 2019) did not include any information about participants' consent and how confidentiality was preserved. One study (Clarke et al., 2020) only briefly mentioned participants' confidentiality but did not explain how this was maintained.

All the included studies used an established qualitative method and described their analytical process, although their level of detail varied. All the studies presented their findings including at least some of their data. Two studies (Clarke et al., 2020; Sciberras & Pilkington, 2018) did not include some of their findings due to lack of sufficient evidence or relevance to the research question. The findings in Sim et al. (2016) appeared to reflect the structure of the interview questions rather than providing an analytic narrative based on the data. All included studies employed at least one credibility check, including team debriefing and consultation amongst the authors and research supervisors (Clarke et al., 2020; Hammond et al., 2018; Papadomarkaki & Lewis, 2008; Sim et al., 2016), involving additional analysts (Norrman Harling et al., 2020), using memos and reflexive diaries (Cramond et al., 2020; Turnbull & Rhodes, 2019), carrying out multiple reviews of theme and code identification processes (Reitano, 2021), and participant

validation procedures (Clarke et al., 2020; Sciberras & Pilkington, 2018). All the studies included in the review presented their findings in relation to their research questions. All except one of the studies included in the review (Papadomarkaki & Lewis, 2008) discussed the generalisability and/or transferability of their findings as one of the limitations of the research. All included studies discussed their findings in relation to the existing literature and made at least some recommendations for future research and practice.

The methodological assessment of the studies included in this review highlighted some methodological strengths and weaknesses. The lack of reporting on dropouts and exclusions in seven of the nine included studies implied that the risk of recruitment and selection bias was not addressed. Six studies did not explicitly discuss data saturation issues. While data saturation can be operationalised in different ways (Saunders et al., 2018), it is important for researchers to consider it in order to increase credibility and transparency (Fusch & Ness, 2015). Almost half of the papers included did not specifically discuss reflexivity and its impact on their study, which impedes wider implications on their credibility (Dodgson, 2019). Limitations around generalisability and transferability have been acknowledged in eight of the nine studies. The qualitative methodologies and the small sample sizes of these studies hinder generalisations to wider populations of psychological therapists and practitioners. Overall, all the studies included in the review provided useful data to address the research questions.

Table 2.4*Summary of Critical Appraisal using the Qualitative CASP Checklist (CASP, 2017)*

Summary of Assessment of Methodological Quality using CASP checklist (CASP, 2017)	Study 1	Study 2	Study 3	Study 4	Study 5	Study 6	Study 7	Study 8	Study 9
	Hammond et al. (2018)	Norrman Harling et al. (2020)	Turnbull & Rhodes (2019)	Papadomarkaki & Lewis (2008)	Cramond et al. (2020)	Reitano (2021)	Sciberras & Pilkington (2018)	Clarke et al. (2020)	Sim et al. (2016)
1. Was there a clear statement of the aims of the research?	√	√	√	√	√	√	√	√	√
2. Is a qualitative methodology appropriate?	√	√	√	√	√	√	√	√	√/X
3. Was the research design appropriate to address the aims of the research?	√	√	√	√	√	√	√	√	√/X
4. Was the recruitment strategy appropriate to the aims of the research?	√	√	√	Can't tell	√	√	√	√	√/X
5. Was the data collected in a way that addressed the research issue?	√	√	√	√	√	√	√	√	√
6. Has the relationship between researcher and participants been adequately considered?	√	√/X	√/X	X	√	√/X	√	√	√
7. Have ethical issues been taken into consideration?	√	√	√/X	Can't tell	√	√	√/X	√/X	Can't tell
8. Was the data analysis sufficiently rigorous?	√	√	√	√	√	√	√/X	√/X	√
9. Is there a clear statement of findings?	√	√	√	√	√	√	√	√	√
10. How valuable is the research?	√	√	√	√/X	√	√	√	√	√

Note. √: fully met; √/X: partially met; X: not met; Can't tell: unable to assess.

The Experience and Impact of Burnout

Therapists' experiences of burnout (and related concepts) and its impact were described in all the included studies. Therapists reported a number of physical, emotional and psychological difficulties associated with burnout, which significantly affected their lives. Therapists talked about feeling fatigued and struggling to focus at work, describing a sense of 'being there but not being there' (Clarke et al., 2020). The emotional impact of these difficulties was evidenced by the participants' experiences of feeling numb and demotivated. Similarly, their professional efficacy and emotional availability were also affected. As a result, therapists reported experiencing decreased personal accomplishment, which led to being unable to work (Turnbull & Rhodes, 2019).

One of the participants described the intense experience of feeling exhausted and fatigued due to stress and burnout:

'I've had these setbacks with burnout ... I was sitting in my car after an intense week, where I've done lots of travel and done things in other places, in my job. And afterwards, I had to stop the car and sort of let it spin for a while, and get out. And I got so scared, I thought 'Dammit! My brain is whacked now'' (Norrman Harling et al., 2020, p. 9).

Another participant talked about the lack of motivation and sense of dread experienced when feeling burnt-out:

'... One of the main things I remember is driving to work. . . just wishing I felt sick that day or, you know, that I get a flat tyre or something just so I didn't have to go' (Hammond et al., 2018, p. 7).

Four of the included studies (Clarke et al., 2020; Papadomarkaki & Lewis, 2008; Sim et al., 2016) highlighted the extent to which burnout affected therapists' personal lives and relationships. This lack of emotional availability experienced by therapists when feeling depleted and burnt-out seemed to permeate their personal relationships with family and friends, leading to reduced social contact, isolation and loneliness. As one of the participants described:

‘...I’m just like a zombie at the end of the day...And then kind of having that blunt, you know, when other people tell you stuff, you’re just kind of like ‘I wanna have that emotion, and I wanna show you that, but I’ve literally got nothing left in the tank’, ‘...And so it feels like the, the, the more, um... infinite some of those levels [of empathy] are in the room, in therapy, then the more finite they become out there in personal relationships’ (Clarke et al., 2020, p. 7).

Participants stressed how the experience and impact of burnout were entangled with their personal circumstances. One of the therapists shared the sense of failure that pervaded professional and personal aspects of their life:

‘It was like a perfect storm, I was feeling like a failure in the three big aspects of my life, as a mum, as a wife, and as a psychologist’ (Turnbull & Rhodes, 2019, p. 55).

Factors Contributing to Burnout

Eight studies identified factors that contributed to the development and experience of therapist burnout. These factors ranged from organisational and systemic issues to personal difficulties experienced by therapists. However, systemic and organisational pressures were described as the most significant factors contributing to therapist stress and burnout:

‘I find myself today hanging on to my client-work to keep me motivated because it’s the system that sometimes feels like an obstacle to my work...’(Sciberras & Pilkington, 2018, p. 154).

The lack of adequate resources, time pressures, working overtime, the impact of non-clinical work, such as administration and managerial tasks, high caseloads, poor quality supervision, and the clinical complexity of their work were the most commonly faced challenges. Therapists identified the lack of training to support their clients adequately, a poor understanding of their role in the teams, the subsequent ambiguity and uncertainty about the nature of their work, and the ethical challenges caused by the disparity between increasing demands and poor resources as significant factors contributing to burnout. These factors fuelled their sense of powerlessness and hopelessness, as one of the participants stated:

‘It’s straining when we don’t have the resources, when we know that we could have done something, but the resources aren’t enough. (...) So we don’t feel like we can stand behind what we deliver’ (Norrman Harling et al., 2020, p. 8).

Three studies (Papadomarkaki & Lewis, 2008; Reitano, 2021; Sciberras & Pilkington, 2018) linked the ethical issues experienced by the therapists to the difficulties of working within a medical model. Therapists reported facing ethical dilemmas such as being asked to persuade their clients to engage in therapy, following the recommendations of the medical team (Reitano, 2021), and doubting the value of their input, particularly when being requested to provide short-term interventions, perceived as inflexible and unhelpful (Papadomarkaki & Lewis; Reitano, 2021). The experience of these challenges conveyed a sense of powerlessness that left therapists frustrated at not feeling ‘trusted’ and ‘valued’ (Sciberras & Pilkington, 2018). As one participant highlighted:

‘I felt that I was not valued as a professional. My work was not being seen and valued for what it was . . . so when I started to experience this, I said: ‘This is not why I became a psychologist, this is not exactly how I wanted to work! . . . I was not trusted and that was my major issue with this’ (Sciberras & Pilkington, 2018, p. 154).

These studies emphasised the tensions that burnt-out therapists experienced within the medical model, both within the public and private sector. Their experience of burnout was associated with the challenges faced within a medical system that was perceived as rigid and hierarchical, where doctors and psychiatrists would take the most important decisions, including those related to the provision of psychological interventions. Therapists reported conflicting feelings stemming from ethical dilemmas and disagreeing with the dominant values of the medical model, which did not focus on developing a collaborative and empowering approach to supporting clients. As one of the participants described:

‘My role in the mental health system is something that often does make me feel anxious because I feel that (...) I don’t sort of fit in with the medical model, which is the prevalent view in the service that I

work in, and (...) I have a lot of doubts about what I am doing sometimes, whether we really help people that much in the long run or not' (Papadomarkaki & Lewis, 2008, p. 44).

Strategies that help to Prevent and Reduce Burnout

All the included studies highlighted strategies that can help to prevent and reduce burnout. All but two of the included studies (Clarke et al., 2020; Papadomarkaki & Lewis, 2008) identified implementing self-care strategies as a way of reducing and preventing burnout. Participants described self-care as a set of tools to embed in their routine, including looking after themselves physically (e.g. eating and sleeping well), seeing family and friends, and nurturing hobbies and interests in their spare time. Participants saw self-care as an essential component in 'building resilience' (Norrman Harling et al., 2020; Reitano, 2021) and developing a true and 'authentic self' (Turnbull & Rhodes, 2019). One participant described how the implementation of self-care strategies helps to prevent stress and fatigue:

'I'm much better at noticing my compassion fatigue now. I can see what's happening (...) and I can try and change things. (...) Like 'oh, now this happened, I have to change tracks here' (Norrman Harling et al., 2020, p. 10).

Seven studies discussed the impact of supervision on therapist burnout. Participants described good quality supervision as a fundamental space to process difficult feelings and emotions related to their work, while maintaining adequate standards of good practice. This 'great source of support' (Reitano, 2021) allowed them to share their challenges without feeling judged:

'Supervision has taken the pressure off me; it's allowed me to share what's going on for me (...). Sometimes the supervisor can help me to see something in a different way, to look something in a different way and I'll think: 'oh, yeah!' and I'll go on from that way' (Papadomarkaki & Lewis, 2008, p. 45).

Five studies (Norrman Harling et al., 2020; Papadomarkaki & Lewis, 2008; Reitano, 2021; Sciberras & Pilkington, 2018; Sim et al., 2016) explored the role of peer support in reducing

burnout. Participants described the support they receive from other colleagues as ‘vital’ and ‘invaluable’ for managing work-related stress. One participant, for example, talked about the restorative nature of peer support:

‘[At lunchtime I] go into the staff lounge because there’s a good mix of people in there ... we jokingly refer to it as the no empathy zone ... we laugh at ourselves ... it’s restorative’ (Sim et al., 2016, p. 392).

Five studies (Cramond et al., 2020; Norrman Harling et al., 2020; Sciberras & Pilkington, 2018; Sim et al., 2016; Turnbull & Rhodes, 2019) highlighted the importance for therapists to find meaning in their professional role. Job satisfaction achieved through finding meaning and purpose in their day-to-day work was seen as a helpful strategy to alleviate burnout. Therapists described working with people in distress as ‘a privilege’ and ‘an absolute humbling honour’ (Cramond et al., 2020). Seeing improvements in clients’ quality of life was highly valued by therapists and seen as ‘the biggest reward you can get’ (Sciberras & Pilkington, 2018).

Discussion

The present review aimed to explore therapist burnout from a qualitative perspective, synthesising studies to develop a richer understanding of the difficulties and challenges experienced by psychological therapists, as well as their professional and personal coping strategies. The findings highlighted that the experience of burnout in therapists is complex, affecting a number of areas, including their physical and emotional wellbeing, and the boundaries between personal and professional lives. Participants talked about feeling depleted and emotionally disconnected from their role, and being unable to support their clients effectively. This is consistent with existing research on therapist burnout and its impact on their wellbeing and professional effectiveness (Morse et al., 2012; Simionato et al., 2019).

The impact of burnout on therapists’ personal lives was also evidenced, leading to reduced social engagement and lessened ability to connect and empathise with others. It appears that

therapists' reduced effectiveness and motivation impaired their ability to engage in therapeutic work meaningfully, thus reinforcing their dissatisfaction. These findings contribute to existing research on therapist burnout, stressing the link between the manifestations of burnout, therapist effectiveness, absenteeism and turnover (Connor et al., 2018; Maslach, 1982; McCormack et al., 2018; Simionato & Simpson, 2018; Simpson et al., 2019).

The review also highlighted some important contributing factors to developing burnout. Participants identified the systemic and organisational challenges they faced as the most significant contributing factors. It appears that therapists perceive systemic and organisational challenges as something they have little or no control over, which fuels their sense of powerlessness and hopelessness. Some of these organisational difficulties seemed to foster the awareness of clashing values, with related ethical implications. Therapists experience ethical dilemmas stemming from dealing with systemic issues they do not feel in control of, which can increase the sense of responsibility they carry (McCormack et al., 2018; Simionato et al., 2019). Similarly, participants found working within services that adopted a medical model as their organisational framework difficult. The clash of perspectives and beliefs, particularly in relation to offering collaborative, patient-centred and psychologically informed care to clients, appeared to raise ethical concerns that made participants feel devalued and unappreciated, which contributed to the development of burnout. As others have suggested (Simionato et al., 2019), exploring the ethical and values-based implications of burnout can help to gain a deeper and more comprehensive understanding of the issues faced by psychological therapists.

The findings of this review have emphasised the importance of individual and systemic coping strategies to reduce therapist burnout. Implementing self-care strategies was perceived as one of the most effective strategies to prevent and alleviate burnout. It seems that participants found the prompt use of self-care and wellbeing tools essential to prevent burnout and foster wellbeing. The wide range of tools mentioned by the participants suggests that self-care strategies can be

personalised and customised to meet their individual needs. It has been theorised that self-care acts as a buffer, enhancing professional satisfaction and thus protecting against the effects of burnout and preserving wellbeing (Rupert & Dorociak, 2019). This review also validated the role of systemic and organisational strategies in preventing and managing burnout, such as effective supervision and peer support. Participants found good quality supervision very valuable in preventing burnout and maintain wellbeing, particularly when processing their own feelings and emotions. Adding to existing literature in the area (Connor et al., 2018; Simionato et al., 2019), the review found that this focus on self-reflection, rather than case-management, plays a key role in preventing burnout and promoting therapist wellbeing, and can provide opportunities to consider and address organisational and systemic factors contributing to burnout. The findings of the present review highlighted that key role of peer support when facing work-related adversity and burnout. Participants talked about peer support and supervision as a restorative space where difficulties are normalised both formally and informally. It seems that this flexible nature of peer networks allows therapists to maximise opportunities to give and receive support, thus addressing a wide range of therapist needs (Rothwell et al., 2019). Finally, finding meaning in day-to-day work was also seen as an effective coping strategy to mitigate therapist burnout. Participants valued being able to help others and being part of their recovery journey. Seeing improvements in clients' wellbeing and quality of life enables therapists to feel valued and experience a sense of purpose. Being able to conceptualise work-related stress in relation to meaning and purpose has been shown to be a healthy coping mechanism that increases stress tolerance and, more generally, work-related ambiguity and uncertainty (Iannello et al., 2017).

Clinical Implications and Recommendations

The findings of this review demonstrate the impact that therapist burnout can have on their ability to work effectively, which has important implications in terms of staff absenteeism, turnover and retention. This appears in line with previous findings suggesting that lower therapist wellbeing

is associated with increased likelihood to leave their roles (Summers et al., 2021). Services should consider promoting a culture in which staff wellbeing is safeguarded. National guidelines and policies are increasingly recognising that preserving and maintaining staff wellbeing also has longer-term economic benefits, as a recent report by the National Health Service (NHS) in England underscored (Health Education England, 2019). Managers and supervisors should be trained to discuss and review burnout factors and related difficulties regularly with their supervisees, offering access to additional support and training when needed (Simionato et al., 2019).

Supervision remains a cost-effective preventative measure for therapist burnout. The findings of this review provide evidence that therapists utilise supervision to manage and reflect on their own feelings and emotions. As evidenced in the present review, in addition to offering case-management, effective supervision should provide a space for therapists to reflect on systemic and organisational challenges, and the impact this has on their clinical work. Given its focus on the therapist's emotional challenges, self-reflection in supervision may be a more effective measure to prevent therapist burnout (Jones & Thompson, 2017; Rothwell et al., 2019; Simionato et al., 2019). Relying on peer support was also validated as an invaluable coping strategy. Services should facilitate relational and peer-based activities, such as mindfulness and self-compassion classes, offering therapists opportunities to engage meaningfully with their colleagues (Lomas et al., 2019; Simionato et al., 2019). Evidence shows that relational networks increase awareness of wellbeing-related difficulties, promote compassion within the workplace (Simpson et al., 2020), and address needs that formal supervision tends to neglect (Rothwell et al., 2019). Finally, this review highlighted that finding meaning in their work and appraising stress in relation to values and beliefs systems helped therapists to manage burnout-related challenges. Services should consider psychoeducational training and practices that enhance self-reflection, such as mindfulness and reflective practice, to encourage therapists to get in touch with their values and embrace work-related stress as a natural part of their work (Lomas et al., 2019; Simionato et al., 2019).

Strengths, Limitations and Future Research

To our knowledge, this is the first systematic review synthesising qualitative studies on burnout in psychological therapists. The systematic screening of the papers conducted referencing the eligibility criteria was enhanced by inter-rater reliability checks of 25% of samples both at title and abstract and full-text review stages. These were carried out by an independent reviewer who was external to the research team. The methodological appraisal of the included papers was discussed and consensus reached with the second (J.O.) and third authors (P.F).

One of the limitations of this review was related to the definition of psychological therapist. This encompassed a number of professionals, including different kinds of psychologists and psychotherapists, but excluded other professionals, such as sport psychologists, counsellors, trainees, and students. Studies including these professionals could provide further insight into the experiences of burnout in psychological therapists. Exploring the experiences of burnout in education and training settings through the recruitment of trainees and students could help to gain a more comprehensive understanding of this phenomenon in psychological therapists early in their professional development, thus uncovering further learnings. All the studies included in this review used qualitative methodologies with small sample sizes, and therefore the transferability of the findings need to be considered with caution. Including studies using mixed-method designs and larger sample sizes could increase the transferability of findings in this area. The review included only studies that were peer-reviewed, thus increasing the risk of publication bias. Similarly, it did not include single case-studies, commentaries, personal reviews or reflections, books, or book reviews, which could provide valuable data for future studies on burnout in psychological therapists.

Conclusion

The findings of this review have highlighted that experiencing burnout has a significant impact on psychological therapists' personal and professional lives. Systemic and organisational

difficulties were identified as the most significant contributing factors to burnout. Implementing self-care and wellbeing strategies, relying on supervision and peer support, and finding meaning in their work were the most helpful strategies to prevent and reduce burnout reported by the participants. Clinical recommendations and implications for services and training programmes include the promotion of workplace cultures in which staff wellbeing is protected. Further research on therapist burnout using different methodological approaches and larger samples is needed to increase transferability. Adopting distinct conceptualisations of burnout and including other kinds of psychological therapists could provide further insight into the experiences of therapist burnout.

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Chapter 3.

Bridging Chapter

Word count (excluding references): 577

Chapter 2 contained a systematic review that explored therapist experiences of burnout, providing an insight into the factors contributing to work-related stress and the coping strategies they utilise to manage it. Given the paucity of qualitative systematic reviews synthesising studies on therapist burnout, the review offered a broader understanding of the experiences of work-related challenges and, crucially, what helps therapists to adapt to them.

Research on burnout has historically focussed on the role of risk and protective factors (Connor et al., 2018; Luthar et al., 2000; McCormack et al., 2018) and personal characteristics of the therapist (Simionato, 2018; Simpson et al., 2019). While it is important to identify the factors and coping strategies that affect the development of burnout, more research is needed to uncover the processes of *how* individuals adapt to work-related adversity (Cicchetti, 2010; Luthar et al., 2000). Research on staff burnout in mental health services has predominantly focussed on reducing stress by improving coping skills (Morse et al., 2012). However, their effectiveness has been shown to be short-lived (Awa et al., 2010). While targeting vulnerability and problematic factors can contribute to reducing burnout, exploring how individuals develop strength and positive qualities can enable services to capitalise on the resources available within specific populations (Luthar & Cicchetti, 2000; Morse et al., 2012). In addition, adopting a strength-based approach can help to design strategies and interventions that promote positive change and competent adaptation, thus focussing on prevention rather than treatment. The importance of designing preventative interventions and programmes has also recently been acknowledged in health research (NHS England, 2019). Moreover, given the complexity of burnout, solely addressing individual risk and vulnerability factors can lead to an oversimplistic understanding of this phenomenon, neglecting the multitude of influences that surround it (Luthar & Cicchetti, 2000).

Research has highlighted that psychological therapists are vulnerable to experiencing burnout (Bearse et al., 2013; Simpson et al., 2019), which can have a significant impact on staff wellbeing and professional efficacy, compromising retention and increasing turnover (Simionato et

al., 2019). Recently, more attention has been given to the dynamic, multi-dimensional and developmental processes underlying the adaptation to stress and the promotion of resilience (Ungar, 2011). A number of models of resilience in psychological therapists have been developed, highlighting its complex nature encompassing personal, occupational and environmental dimensions (Clark, 2009; Hou & Skovholt, 2019; Moosath, 2014).

In England, the PWP role, typically found in IAPT services, has been recognised as a psychological profession by the Psychological Professions Network (NHS England, 2021). The IAPT programme, established in 2008, has historically faced high levels of staff turnover, struggling to retain its workforce (National Collaborating Centre for Mental Health, 2018). Research has shown that IAPT practitioners, who provide psychological interventions for common mental health difficulties, experience high levels of burnout, which might be contributing to their high turnover rates (Delgadillo et al., 2018; Westwood et al., 2017). Resilience has been associated with higher levels of clinical effectiveness, organisational skills and confidence in IAPT therapists (Green et al., 2014; Pereira et al., 2017). Understanding PWPs' resilience-building processes can help services to assess where and when to intervene to address individual, professional and organisational difficulties. In addition, an exploratory model of resilience can allow PWPs to identify what helps them to thrive in their role, despite the difficulties and challenges they face. The next chapter presents a qualitative empirical study that explores the resilience-building process in the IAPT PWP role, and the professional and personal implications of this process.

Chapter 4.

Empirical Paper

**Prepared for Submission to the Psychology and Psychotherapy: Theory, Research and
Practice journal (Appendix C)**

Word count (excluding references, tables and figures): 6337

Title: THE PROCESS OF BUILDING RESILIENCE IN THE INCREASING ACCESS TO PSYCHOLOGICAL THERAPY PSYCHOLOGICAL WELLBEING PRACTITIONER ROLE: A QUALITATIVE GROUNDED THEORY STUDY

Short title: *BUILDING RESILIENCE IN THE IAPT PWP ROLE*

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Abstract:

Objectives: This study sought to develop an explanatory model of the resilience-building process in Psychological Wellbeing Practitioners (PWPs) working within the Increasing Access to Psychological Therapy (IAPT) programme.

Design: A qualitative design was conducted, using a grounded theory methodology.

Method: Participants were recruited from two IAPT services in the National Health Service (NHS), which were part of the same Mental Health Trust. Ten PWPs were interviewed via videoconferencing using semi-structured interviews.

Results: An explanatory model of resilience in PWPs encompassed three phases: the experience of work-related challenges, the connection with their values and the related appraisal of adversity in resilient ways, and the implementation of effective coping strategies.

Conclusions: The model highlights that PWPs develop resilience through values-based sensemaking and by proactively engaging in effective coping mechanisms. This study contributes to the current understanding of the process of resilience in PWPs. More research is needed to explore the developmental processes underlying PWPs' resilience. The implications of the findings in relation to existing conceptualisations of resilience are explored. Recommendations for future research are also given.

Keywords:

Burnout, resilience, mental health, IAPT, psychological wellbeing practitioners, grounded theory

Acknowledgements:

We would like to thank the PWPs who participated in the study, sharing their thoughts, experiences and reflections, without which this research would not have been possible.

Declaration of Competing Interests:

None.

Introduction

Over the past fifteen years psychological services in the UK have been transformed by the introduction of the Increasing Access to Psychological Therapies (IAPT) programme, which aimed to expand access to evidence-based psychological treatment for people with common mental health difficulties, such as anxiety and depression (Clark, 2018; Richards & Whyte, 2009). One of the key features of IAPT is its adherence to the clinical guidelines provided by the National Institute for Health and Care Excellence (NICE). The NICE guidelines recommend a stepped-care model of service delivery, offering the least intrusive interventions first (NICE, 2011). Currently, the IAPT programme offers access to almost a million clients and treats over 560,000 clients per year in England (Clark, 2018).

The IAPT programme has relied on the recruitment of a new workforce to deliver therapy within its stepped-care model. In addition to the more traditional High Intensity CBT Therapist (HIT) role, IAPT introduced the Psychological Wellbeing Practitioner (PWP) role to ensure the provision of low-intensity CBT interventions for mild to moderate anxiety and depression (Richards & Whyte, 2009; Robinson et al., 2012). Low-intensity treatment can be delivered face-to-face, over the telephone or using online platforms. To undertake this work, PWPs complete a one-year postgraduate certificate in low-intensity CBT based on a national curriculum (University College London, 2015). Trainee PWPs are employed by IAPT services and spend roughly three days working in their services and two days undertaking university work. PWPs receive a minimum of one hour per week of individual or group case-management supervision (Green et al., 2014).

IAPT services have consistently reported high levels of staff turnover in their PWP workforce (National Collaborating Centre for Mental Health, 2018). Whilst many PWPs move into high intensity CBT training after two years of clinical experience (NHS England & Health Education England, 2016), recent research has highlighted that PWPs experience high levels of stress and burnout, which might contribute to these high levels of turnover. Steel et al. (2015), in a

study involving 116 IAPT therapists who completed a web-based survey, investigated predictors of burnout. PWPs' stressful work involvement predicted emotional exhaustion and depersonalisation. The study found that the most significant predictors of therapist burnout were service-related, such as service demands and autonomy. Westwood et al. (2017), in a study involving 201 PWPs who completed an online survey about how much time they spent on a number of work-related activities per week, found that the prevalence of burnout, measured using the Oldenburg Burnout Inventory, was 68.6% among PWPs and 50.0% among HITs. Hours of overtime predicted higher levels of burnout and hours of clinical supervision predicted lower levels of burnout. The likelihood of burnout increased with the number of hours of telephone contact among PWPs who had worked in the service for two or more years. Delgadillo et al. (2018) investigated the impact of occupational burnout on depression and anxiety treatment outcomes in IAPT. Involving 49 therapists and 2223 clients, the study found that therapist burnout, measured with the Oldenburg Burnout Inventory, had a negative impact on treatment outcomes, measured using GAD-7 and PHQ-9. Improving PWP retention is a key IAPT objective (The National Collaborating Centre for Mental Health, 2018) and the National Health Service (NHS) in England has identified staff wellbeing as a critical factor in promoting resilience in its workforce (NHS England, 2016).

There have been numerous attempts to define and standardise the concept of resilience. Heterogeneity in adversity and risk experienced, as well as in the levels of competence obtained, has led to the development of competing ideas and definitions of resilience (Luthar et al., 2000). However, despite this variability, many definitions seem to encompass some common elements: exposure to significant levels of adversity, threat or trauma; the ability to recover from such experiences; and achieving better-than-anticipated outcomes (Luthar et al., 2000; Masten & Barnes, 2018). Historically, research on resilience has focused on identifying risk and protective factors to understand how disadvantaged people, and children in particular, can thrive in adverse circumstances (Garmezy, 1970, 1974).

More recently, research on resilience has shifted its focus from investigating risk and protective factors to understanding key underlying processes, putting emphasis on how these factors contribute to positive outcomes (Cicchetti, 2010). This new attention to the underlying processes of resilience is key to generating theories and identifying preventative and intervention strategies for people coping with adversity. Resilience has therefore been understood as the result of interactions taking place across multiple levels, shaped by processes occurring between the individual and the macro-level systems of culture, society, and ecology (Masten & Barnes, 2018; Ungar, 2011). This study aims to draw on these newer understandings of resilience-building processes to explore the individual, organisational and psychosocial dynamics that contribute to the development of resilience in PWPs.

Due to the recent development of the IAPT programme, research regarding PWPs has been scarce (Green et al., 2014). There is very little research on resilience in PWPs, and the research that does exist is mainly quantitative. A study involving 37 IAPT practitioners and outcome data from 4980 clients investigated the impact of mindfulness and resilience on therapist effectiveness, measured using the Mindfulness Attention Awareness Scale, the Connor-Davison Resilience Scale and the PHQ-9. More effective therapists reported higher levels of mindfulness and resilience compared with less effective therapists (Pereira et al., 2017). Green et al. (2014), in a study involving 21 PWPs and their supervisors across six IAPT services, measured therapist effectiveness in relation to measures of ego strength, resilience and intuition. The results highlighted that more effective PWPs, who had higher rates of reliable and clinically significant improvement, reported greater resilience and organisational skills, and felt more knowledgeable and confident in delivering therapy.

As can be seen, research on resilience in IAPT so far has focussed on factors and associations investigated within cross-sectional analyses, rather than exploring how resilience occurs in PWPs and how they benefit from resilience-building processes. The main aim of this

study is to fill this gap in the existing literature by constructing a theoretically sufficient grounded theory (Strauss & Corbin, 1998) of the resilience-building process in the PWP role, and how this impacts on them personally and professionally. Understanding PWP's' resilience-building processes is of interest to clinical psychology and IAPT services. It can help services to address individual, occupational and organisational difficulties, and provide a greater understanding of what enables PWP's to thrive in the role despite the challenges they face.

Methods

Study design

A critical realist perspective was taken, which postulates that the data, their interpretation and the related findings might not provide direct access to this reality as they only hold true within their specific contexts, structures and interactions (Bhaskar, 2008; Roberts, 2014; Willig, 2013). Grounded theory was used to analyse the data, employing different coding strategies to identify categories of meaning that led to the development of a theoretically sufficient explanatory model. This study followed the methodological guidelines outlined by Strauss and Corbin (1998), which recognise the active role of the researcher in interpreting data and enhancing theoretical sensitivity (Corbin & Strauss, 2008).

Participants

The study recruited PWP's from two IAPT services within the same large NHS Mental Health Trust. Eligible participants were required to (a) be 18 years old or over, (b) have completed a one-year postgraduate or undergraduate certificate based on a PWP national curriculum, and (c) work as a fully qualified PWP within an IAPT service in the UK. This study did not aim to specifically target PWP's who described themselves as resilient, so this was not a prerequisite for participation. Rather, the study aimed to recruit participants who could talk about the process of developing resilience, and the potential challenges and barriers related to this process.

The recruitment of PWPs was facilitated by NHS IAPT service leads, who cascaded relevant information about the study to PWPs in their service, who contacted the first author (M.V.) if they were interested in taking part in the study. Eligible participants who expressed an interest were sent a participant information sheet (Appendix D) and a consent form (Appendix E) to sign prior to taking part in an interview. Ten participants (one male and nine female) were recruited. No eligible participants were excluded or dropped out from the study. The average duration of clinical experience since qualification was 27 months, ranging from 2 months to 12 years.

In line with the data protection legislation (British Psychological Society, 2018), participant's confidentiality was preserved by anonymising recorded interview data, transcripts and verbatim extracts. Recruiting participants from more than one IAPT service also helped to ensure participants' anonymity.

Data Collection

Video-recorded semi-structured interviews were undertaken with PWPs, lasting up to an hour and a half. The duration of the interviews ranged from 54 to 80 minutes, with an average of 67 minutes. These were conducted remotely by the first author (M.V.) using Microsoft Teams. An interview schedule (Appendix F) was utilised as an initial guide, including questions that explored the process of developing resilience in the PWP role. Open questions such as “what is resilience for you?”, “have you been able to develop resilience in your role?”, “how have you developed your resilience?” and “what has helped you develop resilience?” were part of the interview schedule. The interview schedule remained flexible and open so that the conversation could be actively shaped by the participants' reflections, views and language in a natural way. The iterative nature of grounded theory implied the progressive redefinition of the interview schedule within and across interviews, taking into consideration the emerging data, codes and analysis (Strauss & Corbin, 1998). Therefore, in line with theoretical sampling, interviews were transcribed and coded while recruiting participants. This iterative process was conducted until “theoretical sufficiency”, rather than

saturation, was achieved. It has been recommended that theoretical sufficiency can be reached with six to 10 interviews (Clarke & Braun, 2013).

Data Analysis

Interviews were transcribed and the data were analysed using a qualitative grounded theory methodology. This led to the development of a theoretical model describing how PWPs build resilience in their role. The study followed the methodological guidelines set by Strauss and Corbin, which are based on a three-stage model of data analysis: open, axial and selective coding (Corbin & Strauss, 1990, 2008; Strauss & Corbin, 1998). The analytical process was carried out entirely using NVivo qualitative data analytical software (Release 1.5.2, 2021). Open coding (Appendix G) involved an open-minded, line-by-line coding. The emerging codes were labelled to establish categories and a constant comparative approach was employed to achieve theoretical sufficiency. The second stage, axial coding (Appendix H), iteratively explored the relationships between codes, highlighting how they related to each other. This process was facilitated by the emergence of conditions, contexts, strategies, actions and interactions of categories, as well as the consequences of these. The third stage of analysis, selective coding (Appendix I), involved the identification of core categories or concepts, from which the theoretical model of the resilience-building process in PWPs developed (Appendix L). This model was obtained by conceptualising a storyline around the core category while constantly exploring the connections between this and the other categories identified in the analysis (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Comparative and flip-flop techniques (Strauss & Corbin, 1998) were also used during data analysis. For example, having analysed data from participants who had worked as PWPs for shorter periods of time, a decision was made to then analyse the transcript of a participant who had worked as a PWP for several years, therefore allowing broader perspectives and experiences to be made sense of early in the analytical process.

The development of all codes and categories, as well as the resulting theoretical model, were reviewed and discussed with the second (J.O.) and third author (P.F.) throughout the data analysis

process. Data extracts were slightly edited to preserve anonymity and improve readability, when needed.

Reflexivity and Rigour

Theorising contextual effects is one of the key advantages of qualitative research, which aims to gain awareness of participants' views and settings, and the multilevel interactions between contexts (Cohen & Crabtree, 2008). Two authors of this study (M.V. and J.O.) have worked as PWPs in the past. This direct experience enabled them to develop a better understanding of the participants' contexts and perspectives (Yardley, 2000, 2017), in line with the critical realist framework adopted in this research. In order to promote a trusting, open and transparent rapport, participants were made aware of the first author's (M.V.) professional background prior to their interviews.

Corbin and Strauss (2008) recognise that the researcher cannot be viewed as a blank slate as they actively interpret reality. The first author (M.V.) used a self-reflective diary and memos to record significant events and acknowledge personal, social and cultural contexts throughout the research process. The diary also helped to consider and reflect on the researcher's own observations, experiences, interpretations and biases. Such an approach helps to ensure rigour and transparency in qualitative research (Morrow, 2005; Yardley, 2017). The authors also regularly met to discuss and agree on identified themes, and explore the development of the theoretical model. The project sought to ensure quality and rigour of research by using Yardley's (2000, 2017) evaluative criteria and framework, which informed and guided the research process.

Ethical Considerations

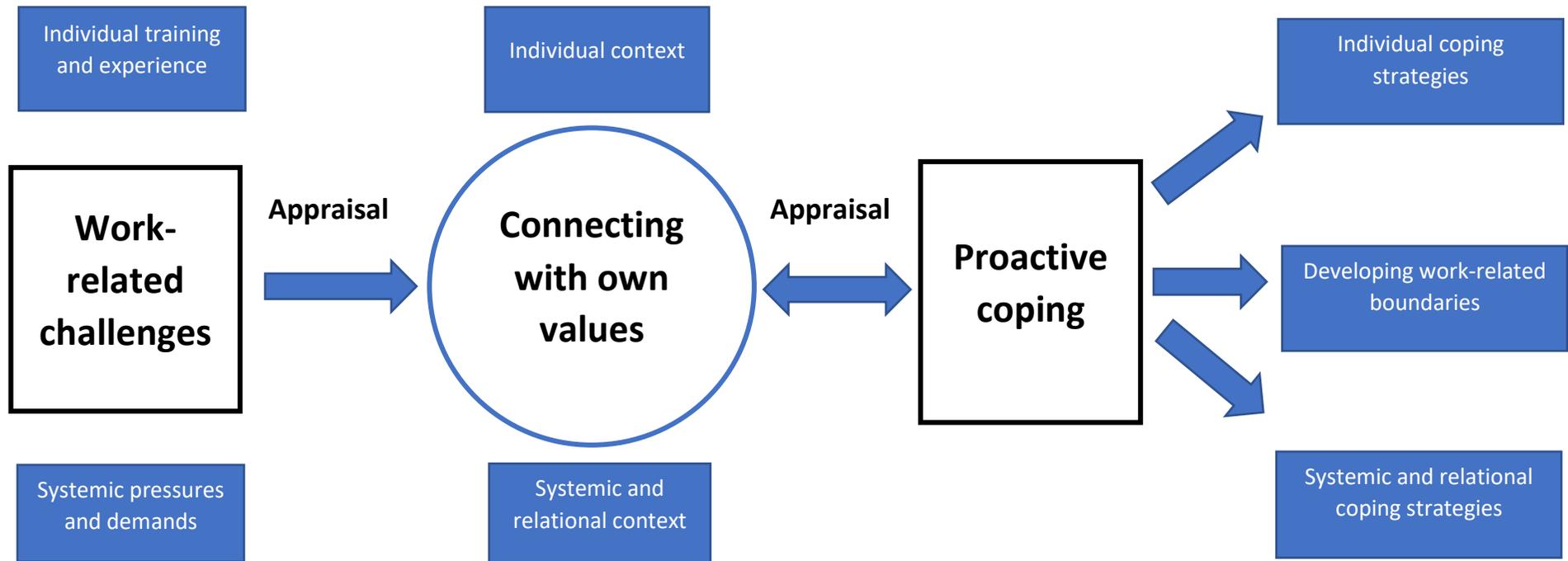
This study requested and gained ethical approval from the NHS Research Ethics Committee (Appendix M) and the Faculty of Medicine and Health Sciences at the University of East Anglia (Appendix N).

Results

Participants described how the process of building resilience in their role developed through connection with their own values and the appraisal of work-related challenges in relation to those values. Three main phases of this theoretical model were identified: experiencing work-related challenges; connecting with their own values and appraising adversity in relation to those values; and implementing proactive coping strategies. This developmental process was established to have individual and systemic dimensions, which impacted on the development of resilience over time. Figure 4.1 shows the key elements of this dynamic resilience-building process. The arrows indicate how elements interlink and the relationship between them. Participants described how finding meaning and purpose encourages them to implement coping strategies when facing adversity, fostering their willingness and ability to cope with difficulties. Participants spoke about feeling that what they do matters and that they are in the role for a reason, which enables them to adapt to difficult circumstances and build resilience over time. They reflected on the meaning of ‘helping others’, ‘making a difference’ and ‘changing people’s lives’. This process of awareness of their values and how they are being nurtured through day-to-day work allows PWPs to navigate and overcome the challenges they experience in their role, reaffirming their sense of purpose and identity. For this group of PWPs this awareness is therefore a key part of the resilience-building process, and how they face and adapt to adversity more generally. Each part of the grounded theory model will be evidenced in turn.

Figure 4.1

Development of Resilience in Psychological Wellbeing Practitioners



Work-related Challenges

The first phase of the theoretical model is related to the difficulties PWP's experience in the role, which affect their levels of resilience. These challenges are important to consider as they are an integral part of the resilience-building process that occurs in PWP's over time. Two main dimensions were identified: systemic and individual challenges.

Individual Challenges

Individual challenges were mainly related to lack of professional and personal experiences. Participants highlighted how lacking personal or professional experience could contribute to the development of work-related challenges. Participant 8 talked about not having had particular life experiences prior to working as a PWP as a barrier to thriving in the role:

‘I think PWP's who haven't had that kind of life experience already, may find it a bit harder than maybe, PWP's that have had some life experience, which has made them either question or go through hard times and see how they are able to manage to cope with those difficult times.’

(Participant 8)

Lack of prior professional experience and training was also described as a significant challenge for PWP's, who may find it difficult to work clinically and manage their workload. Participant 1 highlighted the importance of prior work experience when managing risk and their time more generally:

‘I'm thinking of personal experience with certain colleagues who haven't come with experience and don't know what to expect. They've never kind of dealt with risks, they've never dealt with difficult interactions, and they struggle quite badly to do that. So, I think a really important part of this resilience is having experience of it, and working and organising and managing your time.’ (Participant 1)

Systemic Pressures and Demands

Participants emphasised the impact of the systemic challenges they experienced on their ability to develop and maintain resilience. Work-related pressures and demands, particularly the high volume of clinical work and the related time constraints, were identified as the main challenges that PWPs experience, as Participant 5 explained:

‘I think sometimes, when it is so relentless, yes, there is that sort of okay, I can build up this barrier between work and home, but if it’s just absolutely relentless and nothing seems to be getting easier at work, that can definitely be difficult because you just don’t have that breathing space at all.’ (Participant 5)

Participants reflected on the difficulties associated with balancing administration and clinical work, particularly when managing risk and safeguarding concerns, as Participant 2 highlighted:

‘...when I feel really overwhelmed, when there is too much going on, and when I’ve got referrals to the crisis team or a lot of referrals to the community mental health team or cases that are just not appropriate for wellbeing (the IAPT service), I’m overwhelmed not only with the difficulty that the patients experience, but also having to do all the paperwork. Then I feel like sometimes it’s just too much to cope with and I can feel like being really overwhelmed.’ (Participant 2)

Participants also talked about the stress related to dealing with a high volume of clinical work and the lack of opportunity to reflect on it. Participant 5 spoke about the impact of not being able to process their own feelings and emotions, when needed:

‘But maybe in the long-term that (not being to talk about their own feelings and emotions) doesn’t help because you’ve got all this stuff that you haven’t spoken about or processed. But ultimately, yes, if there are times when I haven’t really been able to open up or talk to people

when I need to, yes, I think that is very difficult because then I think there is something that I've taken on that I just haven't really processed or haven't shared when I might have wanted to.' (Participant 5)

Connecting with Values and Appraising Adversity in relation to Values

The core category of this theoretical model was the participants' connection with their own values and the subsequent appraisal of work-related adversity in relation to those values. Rather than experiencing challenges as overwhelming and unsurmountable barriers, getting in touch with their beliefs allowed the participants to place adversity in a wider context, acknowledging the need to overcome it in order to stay true to the values they believed in. Participants talked about how finding meaning in their day-to-day work encouraged them to take action and proactively implement coping strategies when facing challenges. Participant 3 described how powerful and motivating this process is:

'I get a sense of energy, actually, almost like energised by it. I'm trying to think of the right words, but I think yeah, the word energised is probably the word, that almost feel your body language changes, you're slightly more alert, but not Battle Stations alert, alert as in I need to be on my game here and I'm here to help and I need to be supportive and I need to be as professional as I can be, because this is a situation that requires it.' (Participant 3)

Therefore, it is through this sense-making process that participants were able to adapt to work-related difficulties and develop resilience in their role. Similarly to the first phase of the theoretical model, this core phase has an individual and a systemic dimension.

Individual Dimension

Participants talked about getting in touch with their values when facing challenges as the key element of their resilience-building process. Finding meaning and purpose in their day-to-day work enabled them to build resilience over time, as Participant 2 explained:

‘I don't think if I saw that what I'm doing doesn't have any result on people's lives, then I wouldn't be able to do that job, I'd definitely feel too overwhelmed. But, actually, seeing that you are making changes, that in itself builds your resilience and ability to cope with the other difficult situations that you experience, knowing that feeling needed and feeling like you are in this job for a reason, which is usually wanting to help other people. And when you are meeting that goal, that helps with adapting to maybe more difficult days, still having the awareness that what you do makes sense and makes a difference.’ (Participant 2)

Participant 8 described how reminding themselves of the meaning of their work was particularly helpful when dealing with highly emotive situations:

‘...if you're having that kind of moment where you think, you have one of those days where everyone is risky or there is lots of work to do, or you're just feeling overwhelmed, reflecting on those experiences where you have helped people, you have got them through, can be really helpful because it reminds you as to why you're here.’ (Participant 8)

Participant 7 talked about how their values act as a motivator, encouraging them to implement coping strategies and take action when facing difficulties:

‘...they (their values) are a good motivator, I guess. If I'm having a bit of a bad time or if I'm not feeling as sharp or whatever, I do try and give myself a bit of a kick, I suppose, to be like, okay, well, this is who you are, this is what you are, this is the rules that you live by, so, to speak. You're in this job for a reason, you want to help people, and then that can be quite helpful, just to give that little bit of encouragement, I suppose.’ (Participant 7)

Systemic Dimension

Participants highlighted that the process of connecting with their values and finding a sense of purpose in their work can also develop systemically and relationally. They shared how this sense-making process can be encouraged within the workplace by

promoting a values-based culture, where PWPs feel they can stay and develop in the role despite the challenges they face. This is summarised well by Participant 1:

‘It's just again the reason why I do love the role, and I do think this environment, a lot of what I've said is only possible because of my manager...So it's quite a nice environment that's fostered at the moment in my team. A lot of those values are encouraged, I suppose, in this particular role and particular team that I'm within. It means a lot to me, and that's what makes me think there is longevity to this role.’ (Participant 1)

Participants valued working in environments where they could share their vulnerability with their colleagues when facing difficulties, which enabled them to be open about what they found meaningful in their work:

‘...what I love about the PWP role, and this is also true of working with other PWPs because, you know, people are generally empathic and reflective. It is that you can show vulnerability without it being a weakness or being seen as a weakness and that for me is lovely.’
(Participant 3)

Implementing Proactive Coping

The final phase of the model involves the implementation of proactive coping strategies. Participants explained that getting in touch with their values and finding meaning in what they do encouraged them to implement strategies that helped them to overcome the barriers and the difficulties they face, thus fostering resilience. This phase has three main dimensions: individual coping strategies, work-related boundaries, and systemic and relational strategies.

Individual Coping Strategies

Several participants highlighted the importance of implementing self-care and wellbeing strategies in order to promote resilience. Participant 10 talked about taking annual leave regularly to restore their wellbeing and stay resilient:

‘I always like to have some annual leave to look forward to, even if it's in say 5-6 weeks’ time..., making sure that I’ve always got something that I'm looking forward to. That's something that I’ve found really useful to help keep resilient too.’ (Participant 10)

Participants also discussed the need to “practise what they preach” to cope with challenges and thrive in the role. This included engaging in pleasurable activities, keeping a regular routine and practising the interventions they use in their clinical work, as Participant 1 stressed:

“Sounds a bit silly, but I do practice the interventions. I do do BA (behavioural activation) on myself. I do do these things on myself, classification of worries...” (Participant 1)

Developing Work-related Boundaries

Participants all reflected on the importance of developing work-related boundaries to build resilience. One participant talked about the need to separate work and personal life to be able to enjoy leisure time:

‘I think you almost have to build up this wall or barrier, you know, this is my work life and this is my personal life and no matter what happens today, I still want to be able to enjoy my life outside of work.’ (Participant 5)

Participants also highlighted the importance of managing their time effectively, keeping their clinical work structured:

‘I want them (their clients), at the end of our treatment sessions, to go with these techniques, that I’m there to guide them through so that they use them going forward...but for me, after

doing the role for a while, I realise that by doing that, that boundary-setting is really important and making the sessions as structured as possible.’ (Participant 8)

Participant 10 spoke about establishing work-related boundaries as a skill that PWPs can develop over time by compartmentalising work and private life:

‘I think it's definitely something, as you grow as a practitioner, learning to put those, I wouldn't say they were boundaries, but learning to separate and compartmentalise those things is absolutely a skill. Knowing that I've done everything that I can do and this is my time now, this is my personal life and leaving that in that box.’ (Participant 10)

Systemic and Relational Strategies

Participants discussed a number of systemic and relational strategies. Using clinical and case management supervision effectively and seeking peer support, when needed, were described as some of the most helpful strategies to develop resilience. Participants shared that they found supervision extremely beneficial to discuss clinical concerns, reflect on their development and contribution to the service, and to feel supported:

‘I am not entirely sure where are the boundaries, but, you know, to just feel like your supervisor's got your back, like there's someone in your corner, that there's someone that you can trust, that you can go to. Whether you need to cry about something that happened at work, or, you know, it's an emotional job.’ (Participant 4)

Peer support was considered invaluable by the participants. Talking to their peers enabled them to process and normalise difficult feelings and emotions, at times even replacing clinical supervision. Participant 4 emphasised the key role of peer support in promoting resilience in the team:

‘...we've created our own kind of resilience space with my colleagues, which is really nice. So, in that space, we do help each other. I'm not necessarily sure if they've been noticing or what

their experience of me is in it, in regard to my resilience, but I think overall as a team or the few people that that are in this group, we do support each other's resilience.' (Participant 4)

Another participant described how essential peer support is for them as it has helped them to stay in the role despite the challenges they faced:

'If I didn't have them (colleagues), I don't know if I would still be in the role. We've got the team chats that we stay in touch with, we basically speak every day.' (Participant 6)

Discussion

This study sought to develop an explanatory model of the resilience-building process in PWPs. The participants described the process of developing resilience through three main phases. The first phase involved the experience of dealing with work-related challenges. The second and core phase of this process was the participants' connection with their values and the subsequent appraisal of work-related difficulties. The third phase highlighted how participants developed resilience through the implementation of coping strategies, following their values-based appraisal of work-related challenges.

In line with existing conceptualisations of resilience (Van Breda, 2011), the current findings suggest that resilience involves the experience of adversity; implies the ability to adapt or 'bounce back'; represents a dynamic and fluid process that occurs over time; and aims to improve wellbeing and coping abilities. The findings seem to fit particularly well with more recent conceptualisations of resilience as something relevant in the context of everyday difficulties, rather than solely in the context of significant adversity (Fletcher & Sarkar, 2013). The findings also mirror existing theoretical models of resilience in psychological therapists and mental health staff as a process of gradual adaptation to work-related challenges (Clark, 2009; Van Breda, 2011). Most importantly, the study highlighted

that it is the values-based sense-making that PWPs go through that promotes the adoption of constructive attitudes towards overcoming adversity, thus fostering resilience.

For the current participants, the first phase of the resilience-building process described the experience of work-related difficulties. The difficulties associated with managing a large volume of clinical work and high caseloads appear to be significant barriers to PWP effectiveness, particularly when combined with poor or limited access to clinical support and supervision (Owen et al., 2021; Westwood et al., 2017). One potential explanation may be that practitioners who deal with a high volume of clinical work and experience time pressure find it hard to balance the available resources and the demands they face. This imbalance fosters a perceived lack of control and autonomy in their role and limited participation in decision-making processes, which can lead to low job satisfaction, stress and burnout (Iannello et al., 2017; Morse et al., 2012).

The second and core phase of the grounded theory described the participants' connection with their own values to appraise the difficulties they faced. Participants shared that getting in touch with their most meaningful values, such as wanting to help others and making a difference in people's lives, enabled them to develop resilience. Most of the relevant literature on therapist burnout has emphasised the need to target negative factors in order to reduce burnout (Morse et al., 2012). The findings of this study stress the importance of exploring sense of purpose and meaning in order to increase therapist involvement, job satisfaction and resilience. It is possible that the focus on achieving national targets in IAPT services moves therapists away from their true values and aspirations, which affects their sense of agency, and their willingness and ability to adapt to challenges. As other conceptualisations of resilience have theorised, the role of values and beliefs is key in

appraising work-related stressors as comprehensible, manageable and meaningful (Hou & Skovholt, 2019; Van Breda, 2011).

The third phase of the resilience-building process in PWPs described the implementation of individual, work-related and systemic coping strategies. PWPs seem to elicit resilience through the use of wellbeing and self-care strategies, such as taking breaks, having time off and engaging in pleasurable activities. It appears that the emphasis on their wellbeing and the related engagement in meaningful and enjoyable activities allows PWPs to detach from work-related concerns and focus on cultivating their own interests. Research has suggested that the regular implementation of self-nurturing behaviours fosters therapists' ability to develop their sense of identity (Hou & Skovholt, 2019). Similarly, PWPs with strong work-related boundaries, such as good organisational and time-management skills, tend to be more resilient and proactive in their approach (Green et al., 2014). Plausibly, therapists with firm work-related boundaries are less likely to take on additional tasks and work overtime, thus maintaining high levels of resilience and preventing burnout (Westwood et al., 2017). The systemic and relational strategies discussed by the participants of this study included relying on peer support, managerial and clinical supervision. Therapists seem to elicit support, encouragement and normalisation of their difficulties through the interactions with their peers, reducing self-doubt and increasing self-confidence (Clark, 2009; Jones & Thompson, 2017). Feeling supported by the supervisor and building a positive relationship based on trust has been shown to boost therapist resilience (Rothwell et al., 2019). This trusting relationship facilitates open and honest discussions in which beliefs and values can be explored safely, thus encouraging therapists to stay true to their belief system (Rothwell et al., 2019).

Clinical Implications and Recommendations

The process of developing resilience described by the participants highlighted the key role of values-based sensemaking and the subsequent use of effective coping mechanisms in managing work adversity. Services should consider the promotion of a values-based culture where therapists feel able to nurture their beliefs and values, as this has been shown to encourage the appraisal of work-related difficulties in resilient ways (Van Breda, 2011). The importance of establishing a values-based culture has been emphasised by the UK's NHS, which has consistently promoted its core values and principles through the publication of the NHS Constitution (NHS England, 2013). Services could consider the use of self-awareness and reflective practices, such as mindfulness-based activities and narrative exercises about meaningful clinical experiences, as these have been shown to enhance sense of purpose and job satisfaction, thus increasing resilience in the workplace (Krasner et al., 2009; Morse et al., 2012; Robey et al., 1991).

Services should promote self-care and wellbeing strategies, and encourage therapists to maintain effective work-related boundaries. It is important for services to regularly emphasise and promote these strategies to nurture a culture of compassion and empathy for both clients and staff, where ethical practice is encouraged. As also acknowledged by NHS England, effective leadership (NHS Leadership Academy, 2013), training and supervision all contribute to fostering this organisational culture in services (Robey et al., 1991; Shakeel et al., 2019; Simionato et al., 2019). Therapist wellbeing should also be supported systemically through the development of peer networks. This can be achieved by designing initiatives that bring professionals together, such as practice-based courses and training, relaxation and leisure activities (Simionato et al., 2019).

Limitations and Future Areas of Interest

Being a qualitative study, this research does not aim to generalise its findings to other populations of PWPs in a statistical sense (Myers, 2000). This is in line with the critical realist stance of the study, which attempted to explore the knowable reality of the resilience-building process in this group of PWPs, yet acknowledging that its data and findings might not be able to provide comprehensive access to this reality as it only remains true within its structures, contexts and interactions (Bhaskar, 2008; Roberts, 2014; Willig, 2013).

Qualitative or mixed-method studies with larger sample sizes might provide further insight into the process of developing resilience in PWPs.

Sensitivity to context (Yardley, 2000, 2017) was particularly important for this study, given the critical realist position adopted by the authors. Two of the three authors of this study (M. V. and J. O.) worked as PWPs in the past, which enabled them to gain a deeper understanding of the structures and contexts in which the resilience-building process developed for this group of PWPs. However, in order to ensure anonymity and given the small sample size, only a limited amount of contextual information about the participants and the settings was provided, which was a key limitation of this study. Furthermore, this study did not use any measures of resilience that could have helped to contextualise the sample and, in turn, the findings. Future research on resilience in PWPs could therefore include specific measures of resilience to further contextualise the sample, the settings and the findings.

As all qualitative research is inherently subjective (Starks & Trinidad, 2007), the authors' personal opinions and biases might have influenced the interview process, transcription, analysis and interpretation of data, as well as the related findings. As outlined within Lincoln and Guba's (1985) evaluative framework for qualitative research, issues of bias, credibility, dependability, neutrality and confirmability are important to acknowledge despite the authors' mitigating attempts to ensure rigour and trustworthiness through the

implementation of techniques to make participants feel at ease during interviews, such as rapport building, the use of reflexivity tools, such as reflective diaries and memos, and regular peer debriefing and scrutiny. Future research could build on these findings to increase transferability (Lincoln & Guba, 1985) between services and contexts, and more generally the breadth of therapist experiences. While this research did not aim to generalise its findings, the patterns, experiences and perspectives included in this study could be applicable to other contexts and settings, such as those related to other psychological therapists and mental health staff. This could be achieved, for example, by carrying out studies with larger sample sizes and involving other IAPT therapists and practitioners, such as HITs, counsellors and psychologists. Studies including students and trainees might provide a deeper developmental understanding of the resilience-building processes in PWPs.

Conclusion

This study aimed to develop an understanding of the resilience-building process in the IAPT PWP role through qualitative interviews with a small sample of therapists. Findings highlighted that this cohort of PWPs developed resilience through the connection with their values and appraising the challenges they faced in relation to their beliefs and values. For the participants getting in touch with their values enabled them to find meaning and purpose in their difficulties, which enabled them to overcome adversity, including through using effective coping strategies. IAPT services and training programmes should promote a values-based culture where PWPs can be true to their values and encourage the use of effective individual and systemic coping strategies. Further research with larger sample size and different methodological approaches is needed to increase transferability.

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Chapter 5.

Discussion and Critical Evaluation

Word count (excluding references): 4458

This chapter aims to further discuss the findings of the systematic review and empirical paper, providing a critical evaluation of their methodological strengths and weaknesses, and suggesting areas of future research. A reflective account of the process of conducting research is also provided.

Overview of Findings

Systematic Review

The systematic review aimed to synthesise qualitative studies exploring the experiences and impact of burnout in psychological therapists, and the strategies they employ to prevent and manage this. Nine studies using a variety of qualitative methodologies met the eligibility criteria and were therefore included in the review. An evaluation of their methodological quality was also carried out.

The findings highlighted that therapist experiences of burnout can be complex and multifaceted, resulting in severe consequences on their personal and professional lives. Therapists reported how the physical, psychological and emotional challenges associated with burnout, such as feeling numb, exhausted and demotivated, also permeated their personal lives, blurring the boundaries between professional and personal experiences. The findings reflect existing research on therapist burnout, stressing its impact on therapist wellbeing and effectiveness, and the related implications for absenteeism and turnover (Morse et al., 2012; Simionato et al., 2019). The review found that systemic and organisational challenges were the most significant contributing factors to therapist burnout. These included the imbalance between demands and resources available, high caseloads, time constraints, working overtime, pressures stemming from administrative duties, poor quality supervision, lack of training, clinical complexity and structural service issues. These findings mirror research on the causes and factors of burnout in psychologists and psychotherapists

(McCormack et al., 2018; Simionato et al., 2019). The review also highlighted the strategies and mechanisms through which therapists prevent and manage burnout. These included individual strategies, such as implementing self-care and engaging in wellbeing activities, and systemic strategies, such as relying on effective supervision and peer support. These findings were supported by previous research (Rothwell et al., 2019; Rupert & Dorociak, 2019). Finally, the findings emphasised the role of meaning and purpose in overcoming work adversity. The sense of achievement and satisfaction stemming from positive and meaningful clinical experiences appears to foster therapists' ability to cope with stress and demands (Iannello et al., 2017; Van Breda, 2011).

Empirical Study

The empirical paper explored the process of building resilience in the PWP role and how this impacts on them professionally and personally. Data were collected through semi-structured interviews, which were then transcribed and analysed using a grounded theory methodology (Strauss & Corbin, 1998).

The findings highlighted three main phases of the PWP resilience-building process: the experience of work-related difficulties, therapists' connection with their own values and the related appraisal of the challenges experienced in relation to their values, and the implementation of proactive coping strategies. Each of the three phases identified in the explanatory model had individual and systemic dimensions. Participants talked about experiencing individual difficulties, such as the lack of personal and professional experience, and systemic and organisational challenges, such as a high volume of clinical work, time pressures, excessive administrative work, clinical complexity and lack of opportunity for self-reflection. Previous research has shown that PWPs are vulnerable to experiencing these challenges, which can lead to low levels of job satisfaction, reduced effectiveness and

burnout (Delgadillo et al., 2018; Westwood et al., 2017). The core category of this process was the participants' connection with their values when facing adversity. Getting in touch with their values, both individually and relationally, enabled therapists to appraise their difficulties in relation to what they found meaningful, thus promoting strength, adaptation and resilience. Other models of resilience have conceptualised the role of values, sense of purpose and positive appraisal in the development of resilience, not only in therapists but also in the context of everyday challenges (Fletcher & Sarkar, 2013; Van Breda, 2011). The final phase of the model relates to PWPs' ability to implement effective coping strategies.

Resilient appraisals of work-related difficulties fostered participants' willingness and ability to proactively engage in coping strategies. Self-care and wellbeing activities, setting and maintaining effective work-related boundaries, and relying on systemic and relational support, such as supervision and peer networks, were the most helpful coping mechanisms employed by the participants. Research has validated the use of these strategies in preventing burnout and promoting resilience in therapists (Green et al., 2014; Jones & Thompson, 2017; Rupert & Dorociak, 2019; Westwood et al., 2017).

Critical Appraisal

Systematic Review

The systematic review had several strengths. The review protocol was registered on PROSPERO, an international database to prospectively register systematic reviews, which helps to increase transparency, reduce reporting bias and minimise the risk of duplications (Booth et al., 2012). To the researchers' knowledge, this is the first qualitative systematic review to synthesise studies on burnout in psychological therapists. Having had an independent reviewer, external to the research team, who reviewed 25% of samples of papers

at title and abstract, and full-text review stages, increased the transparency of the screening process and enhanced the reliability of the findings (Mahtani et al., 2020; Stoll et al., 2019).

Although critically appraising included studies is generally considered an essential step within qualitative systematic reviews, there are still divergent views on how this evaluation should be carried out (Carroll & Booth, 2015; Majid & Vanstone, 2018). This lack of consensus reflects the variety of epistemological views and methodological frameworks operating in qualitative research. While it is important for researchers to be able to assess the quality of the research available in the literature, it has been argued that the use of checklists and quality criteria should not be applied rigidly and uncritically in qualitative research, but should function as a guiding framework in which nuanced and rich descriptions, analyses and interpretations are valued (Dixon-Woods et al., 2004; Schwandt, 1996). Additionally, the word limits set by academic journals, which can hinder researchers' ability to evidence and discuss their methodological rigour, and the plurality of guidelines for quality appraisal, contribute to the complexity surrounding the process of critically appraising qualitative research (Long et al., 2020). Despite this multitude of methodological views, some appraisal tools have been consistently employed by qualitative researchers over the recent years. The Cochrane Qualitative and Implementation Methods Group recommends using the CASP qualitative research checklist (CASP, 2018), which is the most widely used tool in health and social care-related qualitative evidence syntheses (Long et al., 2020; Noyes et al., 2018). Therefore, it was used to critically evaluate the studies included in the review. In order to further increase transparency, the methodological appraisal carried out by the first author (M.V.) was also discussed with the second and third author (J.O. and P.F.) of this study (Pieper et al., 2017). Any disagreements were resolved by consensus.

The review also presented a number of limitations. The first limitation related to the use of the concept of burnout. The review included constructs such as occupational stress, compassion fatigue and emotional exhaustion, which have been conceptually linked in the literature (Nolte et al., 2017; Simionato & Simpson, 2018). Similarly to burnout and occupational stress, these concepts imply the enduring nature of empathic responses that people who work in caring roles provide, which can lead to emotional exhaustion over time (Nolte et al., 2017). However, it has been argued that these constructs may also have their own conceptualisations, representing distinct phenomena (Morse et al., 2012; Simionato & Simpson, 2018). The constructs of secondary traumatic stress and vicarious trauma were not included in the current review. As existing theoretical models of empathy-based stress highlight, there appears to be a direct link between these concepts and exposure to trauma, either episodic or recurrent (Rauvola et al., 2015). Conversely, the conceptualisations of burnout and the other constructs utilised in the review do not rely on exposure to trauma but are more closely linked to emotional and psychological distress experienced within the context of work-related pressures and challenges (Nolte et al., 2017; Patel et al., 2017).

The definition of psychological therapist in the review represents another limitation. Currently, the lack of a universally accepted definition of the role of psychological therapist hinders the standardisation of this construct in research (Castelpietra et al., 2021). Relying on classifications of psychological therapists adopted by professional membership networks for psychological professionals, such as the Psychological Professions Network in England (NHS England, 2021), and reviewing the existing literature on therapist burnout, helped to develop the inclusion and exclusion criteria utilised in the systematic review.

The use of qualitative methodologies and the small sample sizes of the studies included in the review imply that the generalisation and transferability of its findings need to

be considered cautiously (Myers, 2000). Finally, the review only included peer-reviewed papers, therefore the risk of publication bias needs to be acknowledged (Song et al., 2012).

Empirical Study

Yardley (2000, 2017) developed an evaluative framework for qualitative research encompassing a number of essential criteria: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Strengths and limitations of the empirical paper were discussed in relation to these quality criteria.

The first strength of the study relates to sensitivity to context (Yardley, 2000, 2017). Two authors of the study (M.V. and J.O.) worked as PWPs in the past, which enabled them to develop a deeper understanding of the context in which the findings occurred (Yardley, 2000). This direct, first-hand experience implies a prolonged engagement with the research topic, fostering researcher commitment and analytical depth (Yardley, 2000). For example, the familiarity with IAPT settings helped the first author (M.V.) to contextualise participants' accounts and perspectives more effectively by relying on past knowledge and experience. This was particularly evident when discussing the role of values-based sensemaking in the resilience-building process. The first author (M.V.) was able to reflect on his own experience and how connecting with his own values allowed him to overcome work-related challenges when working as a PWP. This process enhanced the researcher's engagement with the data, which helped to establish conceptual relationships between categories that were eventually unified under the core category. In order to further increase the researcher's level of engagement with the context, a pilot interview with a PWP was also conducted. This allowed the first author (M.V.) to test the remote format of the interview and familiarise with the interview protocol, aimed at creating a comfortable and easeful environment for participants (Jacob & Furgerson, 2012). Commitment and rigour (Yardley, 2000, 2017) were

demonstrated through thorough data collection, in-depth analysis, consistent implementation of the chosen methodological approach (Strauss & Corbin, 1998), and regular consultation between the authors. For example, coded extracts were regularly shared with the second (J.O.) and third author (P.F.) to explore the development of codes and categories and how these were supported by the data. Informal member checking techniques to ensure accuracy, such as repeating back information to the participants and asking clarifying questions, were also used during interviews (Cohen & Crabtree, 2008). Transparency was demonstrated throughout the construction of a grounded theory that was developed from the data. Codes and categories were constantly tested against the data to identify differences and similarities, and verify their relationships. Transparency was also demonstrated through a careful selection of rich and nuanced quotes, highlighting the complexity of participants' accounts. For example, the core category 'connecting with own values (to become resilient)' encompassed participants' experience of getting in touch with their values base, emphasising how this process leads to the development of resilience. Participant 2 explained how reconnecting with their altruistic nature (wanting to help other people) enabled them to cope with and adapt to difficult situations. The use of a self-reflective diary and memos when transcribing and analysing the transcripts helped to counter researcher bias and further increased transparency (Morrow, 2005; Yardley, 2017). Coherence (Yardley, 2017) was evidenced by the link between philosophical framework and methodological approach. This study adopted a critical realist framework in which an explanatory theory of resilience-building processes in PWPs was placed. Critical realism posits that, while an objective reality exists, it can only be acknowledged and experienced through specific perceptions, structures and contexts (Bhaskar, 2008). Grounded theory serves this purpose well as it aims to construct explanatory models that can embed multiple characteristics, properties, contexts and dimensions (Corbin & Strauss, 1990; Strauss & Corbin, 1998). Moreover, it emphasises

the importance of processes in theory-building, which develop from ‘the ground’ (the data) through participants’ perspectives and experiences (Strauss & Corbin, 1998). Finally, this paper demonstrated relevant impact and importance (Yardley, 2017) by contextualising its findings and utility. To the researchers’ knowledge, this is the first grounded theory study providing an explanatory model of resilience-building processes in PWPs. The paper contributes to the existing knowledge base in the areas of burnout and resilience in qualitative health research, highlighting important clinical and theoretical implications for staff wellbeing, recruitment and retention.

A number of limitations were also identified. The study acknowledged that, despite the use of reflexivity tools and techniques, the researchers’ personal perspectives, biases and opinions may have influenced the research. While it has been argued that qualitative researchers should resist the positivist temptation to prove that their work can be objective and neutral (Galdas, 2017), it is important to acknowledge that researcher bias can influence all stages of the research process, thus affecting credibility and rigour (Noble & Smith, 2015). Another limitation of the study was related to seeking theoretical sufficiency (Dey, 1999), rather than saturation (Strauss & Corbin, 1998). Theoretical saturation occurs when the researcher notices patterns of redundant or unnecessary data, which no longer contribute to the development of properties and dimensions, thus considering the range of constructs underlying the theory complete (Strauss & Corbin, 1998). However, its conceptualisations and operationalisations have been inconsistent, which has led to the emergence of differing and competing approaches (Saunders et al., 2018). Therefore, this study aimed to obtain sufficient conceptual depth to enable the construction of a theory, rather than reaching a limit beyond which it is not possible to gain new conceptual understandings or insights (Dey, 1999; Saunders et al., 2018).

Theoretical and Clinical Implications

The findings of the systematic review and the empirical paper contributed to the area of therapist burnout and resilience from a qualitative, critical realist perspective. From a theoretical standpoint, the findings highlighted that burnout and resilience are complex and dynamic constructs that are able to encompass several dimensions and properties. Most of the research on therapist burnout and resilience has focussed on measuring the presence or absence of relevant factors, traits and characteristics that could contribute to positive outcomes (Cicchetti, 2010), reflecting a positivist view of these concepts. This tendency has been acknowledged in recent debates surrounding the conceptualisations of adversity, coping and resilience, which have attempted to define and operationalise these constructs (Fletcher & Sarkar, 2013). Adopting a critical realist approach allowed the researchers to provide an alternative framework in which these constructs could be contextualised, aiming to reach deeper levels of understanding (Coleman, 2019). The findings emphasise the developmental processes underlying these constructs, with their structures, contexts and dimensions. Crucially, knowledge of the dynamic processes contributing to burnout and resilience, rather than their static properties, can offer unique opportunities to understand and capitalise on the developmental stages in which adaptation to adversity occurs, such as changes and transitions (Cicchetti, 2010). For example, exploring how therapists transition between training and qualified practice, adapting to a higher volume of clinical work, and dealing with more pressures and demands, can uncover valuable learnings related to resilience-building mechanisms.

The findings of the two papers have drawn attention to the individual and systemic dimensions of burnout and resilience. Most of the intervention programmes to target staff burnout and work-related stress in mental health services have focussed on improving the

individual's ability to manage stress by attempting to strengthen their coping skills (Morse et al., 2012). Broadly, these programmes involve providing cognitive-behavioural interventions, communication and social skills training, and wellbeing and self-care strategies (Morse et al., 2012; Simionato et al., 2019). While these interventions could help to strengthen coping skills and strategies, they might not be sufficient to counter the wider systemic and organisational pressures experienced by therapists, particularly in the long-term, as their effectiveness tends to be short-lived (Awa et al., 2010; Simionato et al., 2019). Increasingly, services and wellbeing programmes are recognising the value of promoting wellbeing systemically and relationally, incorporating activities that enable staff to socialise and develop networks, such as leisure activities, classes and courses (Simionato et al., 2019). Peer support and effective supervision represent cost-effective systemic interventions to prevent burnout and promote resilience in therapists (Rothwell et al., 2019). Encouraging self-reflection in supervision and exploring the impact of systemic and organisational pressures can increase awareness of wellbeing-related difficulties and how these could be addressed (Simpson et al., 2020).

The systematic review and the empirical study also highlighted the role of meaning and values-based sensemaking in coping with and adapting to work-related challenges. A number of models and conceptualisations have theorised the importance of positive appraisal in managing adversity (Fletcher & Sarkar, 2013; Hou & Skovholt, 2019; Van Breda, 2011). Establishing a values-based culture in the workplace can help to promote ethical practice, fostering compassion and increasing job satisfaction, thus enabling therapists to appraise stress in resilient and positive ways (Morse et al., 2012; Simpson et al., 2020). Wellbeing and burnout prevention programmes should focus on fostering these positive qualities and appraisals, rather than solely attempting to reduce stress. Services should consider the use of self-reflection, reflective practice, mindfulness and narrative-based exercises aimed at

exploring sense of purpose, meaning and fulfilment at work (Krasner et al., 2009; Morse et al., 2012).

Future Research

Systematic Review

Given the scarcity of qualitative systematic reviews on therapist burnout, future research should focus on synthesising qualitative studies using well-established methodologies, such as thematic synthesis and meta-ethnography, which are becoming increasingly common in qualitative research (Barnett-Page & Thomas, 2009; Siddaway et al., 2019; Thomas & Harden, 2008). Further research on the role of systemic and organisational factors in the development and management of burnout can contribute to exploring not only how these factors affect therapist wellbeing, but also how therapists cope with workplace adversity through the use of systemic coping strategies. Studies on the experiences and perspectives of students and trainees might also help to reach a deeper understanding of how psychological therapists manage and adapt to work-related difficulties through significant changes and transitions.

Empirical Study

Building on the findings of the empirical paper, more research is needed to further explore the benefits of values-based adaptation in therapists, and qualitative methodologies are particularly well-suited to addressing this gap. Future research could also focus on the development of resilience in trainee PWPs, as there is preliminary evidence suggesting that they may experience higher levels of burnout than qualified PWPs and healthcare professionals in general (Owen et al., 2021). This could lead to a more comprehensive developmental understanding of stress and burnout in PWPs, and, crucially, how their adaptation to these difficult circumstances occurs over time.

Reflective Account on the Research Process

Ontology and Epistemology

The systematic review and qualitative empirical paper were conducted from a critical realist perspective. This view, which captures a realist ontology, and relativist and contextualist epistemologies, postulates that reality exists independently of human perceptions, theories and constructions, and cannot be directly accessed as it is influenced by interacting social practices and contexts (Bhaskar, 2008; Roberts, 2014). Within this framework, this thesis portfolio sought to explore the knowable reality of how therapists experience and develop burnout and resilience in their role. However, in line with the adopted critical realist standpoint, the data, their interpretation and the related findings might not provide direct access to this reality as they only hold true within their specific contexts, structures and interactions (Willig, 2013).

I found reflecting on my ontological and epistemological positions very beneficial to the way I experienced and interpreted the research process, particularly for the empirical study. Throughout the interviews with the participants, we discussed the process of developing resilience as something that we could experience and observe. However, I acknowledged that this process occurs regardless of our observations, perspectives and interpretations. Consequently, our understanding of resilience-building processes in PWPs is limited to what is directly observable, as we can only access this reality through the structures and contexts in which it is placed. For example, when talking about resilience with the participants, I needed to contextualise it within its geographical and historical contexts. We live in a Western society, in the UK, in the 21st century. This reality might not hold true in other parts of the world or in different historical times. It is also work-related, meaning that it might not remain true in other settings. Therefore, my aim as a researcher was to develop

deeper levels of understanding and explanation, rather than generating universal laws or rules (Coleman, 2019).

Systematic Review

Overall, I found developing and conducting a systematic review an interesting experience, filled with many learning opportunities. While I had contributed to systematic reviews in the past, this was the first time that I acted as a lead researcher. I learnt how to formulate operationalisable research questions that led to the development of appropriate key terms. I also learnt about designing effective search strategies when using electronic research databases, and applying inclusion and exclusion criteria to select studies. While these processes are often described as linear and systematic, there was often uncertainty surrounding the decisions that needed to be made. For example, choosing the key terms involved an extensive review of the literature and a thorough conceptual exploration of each term. I therefore learnt to appreciate the iterative nature of the revision processes involved in a systematic review and tolerate the uncertainty related to them. I found carrying out cross-checking procedures with an independent reviewer and using the CASP qualitative research checklist (CASP, 2018) extremely useful tools to increase dependability and credibility, which in turn helped to validate my decisions.

I found supervision invaluable throughout the research process. I regularly consulted with my supervisors to explore doubts and dilemmas, and to reflect on the impact that conducting research had on me. I learnt the importance of achieving an adequate balance between being guided and supported, and being encouraged to act as an independent researcher. I also found using a reflective journal extremely beneficial to record thoughts, perspectives and decisions, as well as challenges and barriers. Throughout the different phases of the systematic review, I often relied on my diary entries to remind myself of the

rationales for some of the key decisions made. The use of a reflective diary also enabled me to be aware of and counter my own biases and assumptions (Morrow, 2005).

Empirical Study

Having worked as a PWP in the past was one of the main reasons for choosing to conduct an empirical study on the development of resilience in PWPs. As a researcher, I value the opportunity to engage in qualitative research as it allows me to connect with participants' stories through the collection of rich, detailed and nuanced data. I felt that my previous background as a PWP would enable me to become more sensitive to the context of the participants, increasing awareness of their experiences and perspectives. I felt privileged to be able to listen to their accounts of resilience and I was grateful to them for sharing their stories with me. However, I was also worried about the impact of bias in collecting and interpreting data, so I tried to remain neutral throughout the data collection and analysis stages. At times, I found it difficult to listen to the participants' stories. Inevitably, talking about resilience involved narratives of work-related distress and difficulties, which I could at least partially relate to. I believe the use of a reflective diary enabled me to identify and reflect on these difficulties, exploring the impact that listening to these stories had on me. Whenever needed, I was also able to discuss and reflect on these dynamics in research supervision, which was invaluablely helpful.

Developing an explanatory model of resilience implied a constant and systematic iterative process of revision to ensure that the codes and categories generated, and the relationships between them, truly reflected the participants' experiences and perspectives. I believe supervision played a key role in this process, enabling me to map out and redefine the development of codes and categories whenever needed, as well as their dimensions, conditions and interactions.

Conducting an empirical study within the context of a global pandemic involved several additional challenges. There was often uncertainty about whether NHS recruitment would be allowed, given that COVID-19-related research had to be prioritised, particularly in the early stages of the project. Consequently, additional effort and time were put into developing contingency plans that helped to identify alternative recruitment strategies and data collection techniques. I learnt the importance of devising an effective and comprehensive thesis proposal able to encompass solutions and strategies to overcome potential challenges and barriers.

Finally, transcribing and analysing data from the 10 interviews was an extremely lengthy process that took months to complete. Going through large amounts of data felt incredibly difficult at times. However, I also had a strong desire to contribute to this area of research and help to promote PWPs' wellbeing and resilience. I believe this desire fostered my motivation and willingness to overcome some of the difficulties faced. Having gained their consent, I am planning to share the findings of this research with the participants of the study, so that they can see the concrete and tangible outcome of their contribution.

Thesis Portfolio Conclusion

The systematic review offers a qualitative synthesis of psychological therapists' experiences of burnout, exploring its impact and how therapists adapt to it. The experience of burnout can have a severe impact on therapists' wellbeing, both personally and professionally. Systemic and organisational factors were identified as the most significant contributing factors to burnout, which has implications for service policies and training. Recommendations for services include the provision of effective supervision with a focus on self-reflection and systemic issues, the implementation of peer-based activities and the promotion of work settings in which therapist wellbeing is safeguarded.

The empirical paper provides an explanatory model of the resilience-building process in PWPs. Resilience was described as a developmental process that occurs through the connection with values and the related appraisal of challenges in resilient ways. Getting in touch with their values enables PWPs to overcome adversity, including through the use of effective coping strategies. Implications and recommendations for services and training programmes highlight the need to promote values-based cultures and the use of individual and systemic coping strategies.

Taken together, these findings stress that burnout and resilience are complex phenomena that can significantly affect therapist wellbeing and effectiveness. Further research in these areas should focus on the processes underlying these constructs to gain a deeper understanding of how therapists' resilient adaptation occurs when facing adversity.

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Appendices

Appendix Item	Appendix Description
A	Author Guidelines for the Mental Health and Prevention Journal
B	Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist
C	Author Guidelines for the Psychology and Psychotherapy: Theory, Research and Practice Journal
D	Participant Information Sheet for the Empirical Study
E	Consent Form for the Empirical Study
F	Topic Guide used for the Empirical Study
G	Example of Open Coding using NVivo (Release 1.5.2) for the Code 'Lack of Time due to Relentless Work' with Researcher's Reflections from the Reflective Diary
H	Example of Axial Coding for the category 'Developing Strategies to Increase Resilience' using NVivo (Release 1.5.2), highlighting the relationships between the category and its related codes
I	Example of Selective Coding for the Core Category 'Connecting with Own Values to Become Resilient' using NVivo (Release 1.5.2)
L	Conceptual development of grounded theory model of resilience in PWPs
M	Letter from the NHS Research Ethics Committee granting Ethical Approval
N	Letter from the UEA FMH Ethics Committee confirming Ethical Approval

Appendix A

Author Guidelines for the Mental Health and Prevention Journal*

*Note: The sections and subsections of the systematic review will be numbered before submission



MENTAL HEALTH & PREVENTION

AUTHOR INFORMATION PACK

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ISSN: 2212-6570

DESCRIPTION

Mental Health & Prevention is a peer reviewed journal dedicated to the prevention of mental and behavioural disorders and mental ill health, and the promotion of mental well-being. Its scope encompasses universal, selective and indicated prevention and mental health promotion across the lifespan. All mental and behavioural disorders are covered, as well as suicide and self-injury. The journal does not cover early intervention or treatment of mental and behavioural disorders. Submissions are welcome on the following topics:

Research on the need for prevention

Research contributing to the development of interventions

Descriptions of major programs, where there is accompanying evaluation

Evaluations of interventions to prevent disorders or reduce risk factors, including controlled and uncontrolled trials and qualitative studies

Protocols for trials

Research on risk or protection factors that has implications for prevention

Psychometrics of prevention measures

Economics of prevention

Workforce development

Prevention policy

Systematic reviews on any of the above topics

Keywords: mental health, mental disorders, behavioural disorders, mental well-being, primary prevention, secondary prevention, universal prevention, selective prevention, indicated prevention, promotion, neurodevelopmental disorders, mood disorders, anxiety disorders, schizophrenia and other psychotic disorders, feeding or eating disorders,

substance use disorders, impulse control disorders, personality disorders, neurocognitive disorders, disruptive behaviour or dissocial disorders, suicide and self-injury

ABSTRACTING AND INDEXING

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Epidemiology, Preventive Medicine, Geriatrics, Alzheimer's, Depression, Mental Health

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Body image, Eating disorders, Digital health, Ecological momentary assessment

Laura Hart, The University of Melbourne, Melbourne, Australia

Mental Health First Aid, Mental Health Literacy, Eating Disorders, Body Image, Suicide, Schools, Weight stigma

Saskia Kelders, University of Twente, Enschede, Netherlands

Digital health interventions, Mobile health, eHealth, Engagement, Intervention development, Process evaluation

Lee Knifton, University of Strathclyde, Glasgow, Scotland, United Kingdom

Public health, Mental health, Stigma, Discrimination, Participation, Action research

David McDaid, The London School of Economics and Political Science Department of Health Policy, , United Kingdom

Economics, Policy issues related to mental health and wellbeing, Public health, Health promotion and suicide and self-harm prevention

Louise R. Mewton, University of New South Wales, Sydney, Australia

Prevention, Technology, Adolescent, Older adults, Alcohol use, Anxiety, Depression, Research methods, Diagnosis

Amy Morgan, The University of Melbourne, Melbourne, Australia

Prevention, Mental health first aid, Stigma, Mental health literacy, Anxiety, Depression, Suicide

Nicola Newton, The University of Sydney, Sydney, New South Wales, Australia

Prevention of MH and SU in young people, ,

Bridianne O'Dea, Black Dog Institute, Randwick, Australia

Youth mental health, Internet interventions

Adrienne O'Neil, Deakin University, Burwood, Victoria, Australia

Interplay between physical and mental health

Dennis J. Petrie, Monash University, Clayton, Victoria, Australia

Health economics; Health inequalities; Applied econometrics, Economic evaluation

Patrick Pössel, University of Louisville, Louisville, Kentucky, United States of America

Broadly depression prevention in adolescents, across basic to intervention research, with interest in mechanisms, ,

Stefanie J. Schmidte, University of Bern, Bern, Switzerland

Prevention and early intervention in psychosis, ,

Sachin Shinde, Sangath, New Delhi, India

Adolescent health and nutrition, Adolescent mental health, Non-specialized health workers, Quantitative research, Qualitative research, Low- and middle-income countries

Karolina Stasiak, The University of Auckland, Auckland, New Zealand

Youth mental health, Internet interventions, Digital health, mHealth, Mental wellbeing, Co-design, Social media and wellbeing

Emily Stockings, The University of Sydney The Matilda Centre for Research in Mental Health and Substance Use, Camperdown, Australia

Smoking, Tobacco, e-cigarettes, Depression, Anxiety, Mental health services, Mental health policy, Systematic reviews and Meta-analysis

Svenja Taubner, University Hospital Heidelberg Center for Psychosocial Medicine, Heidelberg, Germany

Psychotherapy research, Attachment, Mentalization and personality disorders

Marie Yap, Monash University School of Psychological Sciences, Monash, Australia

Parenting, Digital health interventions, Prevention, Early intervention, Child mental health, Youth mental health

Previous Editors

Svenja Taubner, Editor-in-Chief 2016-2018

Psychotherapy research, Attachment, Mentalization and personality disorders

Founding Editor in Chief

Manfred Cierpka†

Family prevention research, family violence, psychodynamic psychotherapy research

GUIDE FOR AUTHORS

INTRODUCTON

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Types of article

Types of Articles

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Appendix B

Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist



CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- ▶ Are the results of the study valid? (Section A)
- ▶ What are the results? (Section B)
- ▶ Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a “yes”, “no” or “can’t tell” to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

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Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

- HINT: Consider
- what was the goal of the research
 - why it was thought important
 - its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

- HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
 - Is qualitative research the tight methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

- HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:



4. Was the recruitment strategy appropriate to the aims of the research?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

- HINT: Consider
- If the researcher has explained how the participants were selected
 - If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
 - If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

- HINT: Consider
- If the setting for the data collection was justified
 - If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
 - If the researcher has justified the methods chosen
 - If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
 - If methods were modified during the study. If so, has the researcher explained how and why
 - If the form of data is clear (e.g. tape recordings, video material, notes etc.)
 - If the researcher has discussed saturation of data

Comments:



6. Has the relationship between researcher and participants been adequately considered?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:



8. Was the data analysis sufficiently rigorous?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider

- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
 - To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider whether

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:



Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature)
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

Appendix C

Author Guidelines for the Psychology and Psychotherapy: Theory, Research and Practice Journal

PAPTRAP AUTHOR GUIDELINES

Sections

1. [Submission](#)
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3. [Manuscript Categories and Requirements](#)
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Please note that the author is responsible for all statements made in their work, including changes made during the editorial process – authors should check proofs carefully. Note that proofs should be returned within 48 hours from receipt of first proof.

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The journal offers rapid publication via Wiley's Early View service. **Early View** (Online Version of Record) articles are published on Wiley Online Library before inclusion in an issue. Before we can publish an article, we require a signed license (authors should login or register with **Wiley Author Services**). Once the article is published on Early View, no further changes to the article are possible. The Early View article is fully citable and carries an online publication date and DOI for citations.

8. POST PUBLICATION

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- The link to the published article can be shared through social media.
- The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).
- For non-open access articles, the corresponding author and co-authors can nominate up to ten colleagues to receive a publication alert and free online access to the article.

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Wiley also helps authors measure the impact of their research through specialist partnerships with **Kudos** and **Altmetric**.

9. EDITORIAL OFFICE CONTACT DETAILS

For help with submissions, please contact: Hannah Wakley, Associate Managing Editor (papt@wiley.com) or phone +44 (0) 116 252 9504.

Author Guidelines updated 28th August 2019



Appendix D

Participant Information Sheet for the Empirical Study

Participant Information Sheet (Version 2) – 11.02.2021 - IRAS N. 292357

“The process of building resilience in the IAPT Psychological Wellbeing Practitioner role: A qualitative grounded theory study”

NHS Research Ethical Approval Number (REC REFERENCE): 21/HRA/0898

My name is Marco Vivolo and I am a Trainee Clinical Psychologist at the University of East Anglia. As part of my Professional Doctorate in Clinical Psychology, I am conducting a research study looking at the process of building resilience in the Psychological Wellbeing Practitioner (PWP) role.

I would like to invite you to participate in this research study. Before you decide whether you wish to take part, it is important that you understand the purpose of the research and what it would involve. Please read this information sheet carefully.

Do I have to participate in the study?

Your participation in this study is entirely voluntary. This means that it is completely up to you whether or not you choose to participate and you are free to decline to take part. If you do choose to participate you will be asked to complete a form so that your consent can be recorded. Before this happens, we will check together that you meet the criteria for the study. Should you decide that you no longer wish to proceed or be involved, you can withdraw from the study at any stage of the interview. In addition, you can request that your data is destroyed and not included in the research for up to two weeks after the interview, after which data removal will not be possible. You do not have to provide a reason for any of these decisions.

What is the purpose of the research?

The primary aim of this research is to explore and understand how Psychological Wellbeing Practitioners develop resilience in their professional role. Research shows that IAPT (Increasing Access to Psychological Therapies) services have consistently reported high levels of staff turnover, particularly in their PWP workforce. Understanding PWP's resilience-building processes is therefore of great clinical interest and can help services to assess where and when to intervene to address individual, occupational and organisational difficulties. It can also allow PWPs to better understand what helps them thrive in the role despite the challenges and the difficulties they face.

What does the study involve?

You would be asked to take part in an audio-recorded interview lasting up to one and a half hours. Given the current COVID-19 related restrictions, the meeting will be conducted via Microsoft TEAMS, Skype for Business or over the telephone, depending on your preference. If the meeting is conducted via Microsoft TEAMS, the interview will be video-recorded. Should the government guidelines in relation to the COVID-19 pandemic change and allow face-to-face contact, in-person audio-recorded interviews will be considered, should this be your preference.

The interview will involve a discussion with me about your experience of developing resilience in your role as a PWP. As part of the interview, the researcher will ask you a bit about yourself, such as your name, gender and age. However, the data will be anonymised and no identifiable information will be disclosed. More specifically, in the interview we will talk about the factors, the processes and the experiences of resilience in the PWP role.

If you decide to participate in this study, you will be asked to complete a consent form to confirm that you understand what your involvement will be and that you are happy to proceed.

Are there any possible benefits to taking part?

One of the possible benefits of taking part in the study is to have an opportunity to share your professional experience in your role, as well as represent other therapists who may have similar experiences. It is hoped that the study will help training providers, PWPs and wider stakeholders to gain a better understanding of workplace resilience in the IAPT PWP role. This may enable services, training courses and PWPs to identify what helps them to thrive in

the face of potential difficulties, as well as what resources, guidance and support might be available to them.

All participants will be sent a £5 Amazon gift voucher to thank them for their participation. To receive the voucher you will need to consent to this as it will be sent to your email address. This information will be stored separately to all other study information. The vouchers will be sent to participants once recruitment has finished.

What are the possible disadvantages of taking part?

It is possible that talking about your experience in your role may be difficult and can cause you to feel upset or distressed. However, you do not have to answer any questions you do not wish to and can stop the interview at any time.

Should you need support with your mental health, I would advise that you discuss this with your GP, as they will be able to provide appropriate advice and guidance. If you require immediate support, please call 999 for the local emergency services. Should any further support or advice be needed, you can find some additional sources of support below.

Samaritans (24-hour service)

Contact number: 116 123 (UK number)

Email: jo@samaritans.org

Website: <https://www.samaritans.org/how-we-can-help-you/contact-us>

Mind (9AM –6PM, Mon-Fri, except bank holidays)

Contact number: 0300 123 3393

Email: info@mind.org.uk

Text: 86463

Website: <https://www.mind.org.uk/>

Confidentiality

How will we use information about you?

We will need to use some of your information for this research project.

All information collected about you throughout your involvement in the study will be kept strictly confidential. Any identifiable information will be stored securely and separately from your consent form and audio-recorded interview. If the interview is conducted via Microsoft TEAMS, it will be video-recorded. Your data, including your recorded interview and transcripts, will be stored using an encrypted and password-protected storage device. Interview transcripts will be anonymised.

We will keep all information about you safe and secure.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

A pseudonym will be used to maintain confidentiality during data analysis and when presenting findings. Identifiable details will be removed before your transcript is seen by anyone else who is not part of the research team. Your interview data will only be accessed by the investigators of the study and professionals from transcription services approved by the University of East Anglia. Any verbatim quotes of your interview transcript included in the research study will be anonymised and all identifying information removed.

Anonymisation will take place two weeks after the interview. However, despite the full anonymisation of any verbatim quotes, it cannot be guaranteed that these quotes or any other data in the research reports and publications will not be recognised by other people.

Academic and professional staff might also be able to access your anonymised data to evaluate the quality of this doctoral research study. However, they will also have a duty to maintain confidentiality. Any data related to your involvement in the research will be transferred to the University of East Anglia's Research Data Storage Facilities, where they will be securely stored, routinely controlled and regularly backed up to avoid data corruption, loss and theft.

Once we have finished the study, your data will be stored for ten years following the final submission of the project, after which they will be destroyed.

The £5 Amazon gift voucher and a summary of the findings of the study will also be sent to you by email, if you consent to this. Your email address will be stored on a password-protected storage device until the end of the research project, after which it will be deleted.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- by asking one of the research team
- by sending an email to m.vivolo@uea.ac.uk, or
- by ringing us on 07444 802499

Are there any exceptions for breaching confidentiality?

In line with the British Psychological Society's Code of Ethics and Conduct, this study will include some exceptions for breaching confidentiality. Should you disclose any information that raises concerns about your safety or the safety of other people, appropriate third parties and services might be contacted without your formal consent. This would normally be discussed with the project supervisors first, unless immediate support was required due to an imminent risk to life or health.

Findings of the study

A summary of the findings will be made available to all participants once the study is complete. If you consent to this, you will be asked to share your email address as the summary will be sent to you by email. Your email address will be deleted once the summary of the findings has been sent.

The findings of this study will be included in my doctoral thesis, which will be held by the University of East Anglia. The findings are likely to be submitted for publication in a peer review journal. Some anonymised verbatim extracts as well as summaries of the main themes identified in the interviews will be published. Audio recordings will not be published. However, any data related to your involvement included in any academic publications that might arise from this research will be anonymised.

Who has organised and reviewed this study?

This study is funded and organised by the University of East Anglia. It has received full ethical approval from the Faculty of Medicine and Health Sciences at the University of East Anglia. The study has also been approved by the NHS Health and Research Authority (HRA) and Health and Care Research Wales (HCRW). This research is being undertaken as a part of a Professional Doctorate in Clinical Psychological.

Information and contact details

Should you have any questions, please do not hesitate to contact me (Marco Vivolo) to discuss these. If you would like to take part in this research, please contact me so that an interview can be scheduled (please see my details below). Before your involvement in the study, you will be asked to read and sign a consent form.

Principal Investigator: Marco Vivolo

Email: m.vivolo@uea.ac.uk

Contact number: 07444 802499

Address: Department of Clinical Psychology and Psychological Therapies,
Norwich Medical School, Norwich Research Park, University of
East Anglia, Norwich, Norfolk, NR4 7TJ.

Primary Supervisor: Dr Paul Fisher

Email: p.fisher@uea.ac.uk

Address: Department of Clinical Psychology and Psychological Therapies,
Norwich Medical School, Norwich Research Park, University of
East Anglia, Norwich, Norfolk, NR4 7TJ.

Complaints and concerns

Should you have any complaints or concerns about how this study has been carried out, please feel free to contact the Director of the Doctorate in Clinical Psychology, Professor Niall Broomfield, whose contact details are included below.

Email: N.Broomfield@uea.ac.uk

Tel: 01603 591 217

Address: Department of Clinical Psychology and Psychological Therapies,
Norwich Medical School, Norwich Research Park, University of
East Anglia, Norwich, Norfolk, NR4 7TJ.

Thank you for taking the time to read this information sheet.



Appendix E

Consent Form for the Empirical Study

Participant Consent Form (version 1) – 23.01.2021 – IRAS N. 292357

“The process of building resilience in the IAPT Psychological Wellbeing Practitioner role: A qualitative grounded theory study”

NHS Research Ethical Approval Number (REC REFERENCE): 21/HRA/0898

Name of researcher: Marco Vivolo, Trainee Clinical Psychologist

1. I confirm that I have read and understood the participant information sheet for the above study and have been able to answer any questions to my satisfaction.
2. I understand that my participation in the study is entirely voluntary and that I am able to withdraw from the study before or during the interview and for two weeks after the interview without giving any reasons.
3. I understand that my interview will be either audio-recorded using a digital recorder or video-recorded using the recording function in Microsoft TEAMS (through the researcher’s university account), and I consent to this recording.
4. I have been told and I understand how any information about me or related to my involvement in the study will be handled: I understand how it will be stored and kept secure, who will have access to it and how it will be used.
5. I understand that should I disclose any information that raises concerns about my safety or the safety of other people, appropriate third parties and services might be contacted without my formal consent. This would normally be discussed with the project supervisors first, unless immediate support was required due to an imminent risk to life or health.
6. I understand and agree that quotes from my interview may be included in research reports and publications, where all data used will be treated anonymously and confidentially.
7. I agree to take part in the above study.

Signature of participant

Name of participant

_____ Date _____

Signature of principal investigator

Name of principal investigator

_____ Date _____

Appendix F

Topic Guide used for the Empirical Study

INTRODUCTION

- Provide some brief information about the study (focus on resilience)
- Remind them of confidentiality (refer back to consent form and participant info sheet and ask if they have any questions about them)
- I know you have signed the consent form already, but can I just check again that you're happy to go ahead with the interview?
- Explain nature of the interview (set expectations, no correct answers, their account/experience is important)
- Remind them of right to withdraw and/or pause, if needed.
- As agreed, the interview will be (video-) recorded (e.g., on Teams)
- Interview will last up to one hour and a half
- Taking notes

Do you have any questions for me before we begin?

RESILIENCE: UNDERSTANDING, PERCEPTIONS, MEANING

- Thank you for taking part in this study. Can I ask you what motivated you to participate?
- What is resilience for you?
- What is the meaning of resilience for you?

(summarise and reflect back, stay curious, could you tell me more about it?)

EXPERIENCES OF RESILIENCE-BUILDING PROCESSES

- Have you been able to develop resilience in your role (if this is not clear yet)?
- How do you know you have developed resilience? What are the markers? What has changed?
- How have you developed resilience in your role as a PWP?
- What enabled you to develop resilience at work?
- Were there any particular challenges or difficulties that you were able to overcome?
- Can you think of any examples of these?
- How did that make you feel? How was that like for you?
- Did anything make it easier for you to develop resilience?
- Did anything make it harder?

(Ask about differences, exceptions, e.g. were there any times when this didn't happen? When was this more likely to happen?)

(summarise and reflect back, stay curious, could you tell me more about it?)

(write down concepts or points to go back to, if needed)

IMPACT OF RESILIENCE-BUILDING PROCESSES

- You told me about.....How did this affect your work? How did it affect other people at work (e.g. colleagues, supervisors, managers)?
- Was this discussed at work? (if yes, what made it possible/easier?) (if not, what made it difficult to discuss?)
- What was it like? How did other people perceive this?
- And outside of work? Did you notice an impact at home and in your personal life?
- How did you perceive this? Did other people perceive this?
- How was your psychological wellbeing as you were going through these experiences (did you notice an impact on your mood, behaviours, and thoughts)?
- Did other people notice an impact?
- How did that make you feel?

(ask about differences, exceptions, e.g. were there any times when this didn't happen? When was this more likely to happen?)

(mmm, okay...stay curious, could you tell me more about it?)

(write down concepts or points to go back to, if needed)

EXPERIENCES OF SUPPORT AND COPING

- Reflecting on these experiences of resilience that you've shared, what was helpful?
- Can you think of any examples of these? What were these support strategies and/or coping mechanisms?
- Have there been any changes in your ability to develop resilience over time, as a result? If so, what are these changes?
- So you identified these changes, can you tell me more about them? What does that tell us about your experience?

(summarise and reflect back, stay curious, could you tell me more about it?)

(write down concepts or points to go back to, if needed)

ENDING

- Thank you for sharing this. Is there anything that you would like to add or talk about that has not been covered yet?
- Thank you for participating in this study. As mentioned in the Participant Information Sheet, a summary of the findings will be made available to all participants once the study is complete. If you consent to this, the summary will be sent to you by email. Would you like to receive this by email?

Appendix G

Example of Open Coding using NVivo (Release 1.5.2) for the Code ‘Lack of Time due to Relentless Work’ with Researcher’s Reflections from the Reflective Diary

R: Researcher

P6: Participant 6

R: Can you tell me a bit about what that relentless looks like to you?

P6: Yes, I think it’s just, a lot of it is lack of time, yes, we’ve got, for example, 45 minutes to do an assessment, 30 minutes to do a treatment session, but actually, in real-life, so often sessions run over, clients are very hard to contain, they haven’t filled on the questionnaires beforehand like they’re meant to or their difficulty is just so complex that you cannot fit it into that time frame.

The screenshot shows the NVivo interface. At the top, a code label 'Lack of time due to relentless work' is selected. Below it, a toolbar contains icons for search, filter, and other functions. The main area displays a transcript snippet with a grey highlight box over the text: '<Files\\Research Interview 6 - PWP study 15-11-2021> - § 1 reference coded [0.89% Coverage]'. Below this, a label reads 'Reference 1 - 0.89% Coverage'. The transcript text is repeated below the screenshot, with the original yellow highlights from the interview transcript visible.

The text highlighted in yellow is a coded extract from an interview transcript highlighting the process of open coding. Below the highlighted text is the code ‘Lack of time due to relentless work’, generated using NVivo. A conceptual label was given to enable potential grouping of codes and categories later in the data analysis process. Conceptual coding promoted further abstraction needed to develop relationships and interactions between categories.

An entry from the researcher’s reflective diary related to the above interview is reported below:

15th November 2021 – Some extremely interesting topics came up, such as telling PWPs they are not resilient doesn’t help with resilience, importance of practising what they preach, balance between professional and personal life, keeping work-related boundaries in place and peer support. Sadly, the participant expressed quite a lot of frustration with the role, related to the systemic pressures and issues (“relentless work”). It made me think about my own experience and reflect on the importance of acknowledging and exploring these difficulties in order to better understand PWPs’ struggles and how to cope with them.

Appendix H

Example of Axial Coding for the category ‘Developing Strategies to Increase Resilience’ using NVivo (Release 1.5.2), highlighting the relationships between the category and its related codes

Codes			
⊕ Name	↕ Files	References	
○ Developing strategies to increase resilience	3	3	
○ Action - Having a structured routine and activities when not at work	1	2	
○ Action - Hitting the pause button to have space to manage stress	1	4	
○ Action - Implementing and reinforcing work-home boundaries	3	5	
○ Action - Keeping track of what you do and follow-up actions	2	3	
○ Action - Managing and organising time effectively to stay resilient	2	5	
○ Action - Managing time effectively to cope with workload	2	2	
○ Action - Noticing when doing too much and making time for yourself	1	2	
○ Action - Taking regular breaks and not overworking when stressed	1	1	
○ Action - Taking time off when experiencing stress and burnout	1	2	
○ Action - Using annual leave to reset and manage stress	3	6	
○ Action - Using mindfulness in day-to-day work	1	3	
○ Consequence - Being able to manage time effectively	2	3	
○ Consequence - Fewer times when there's no energy to manage clinical work	1	1	
○ Interaction - Allowing difficult feelings to be processed	1	2	
○ Interaction - Discussing demands with managers and supervisors	1	1	

An example of axial coding using NVivo is included above. The ‘Developing strategies to increase resilience’ category was related to a number of codes through the identification of conditions, contexts, actions, interactions and consequences. This process allowed the researcher to systematically test these relationships against the data and further develop dimensions and properties that contributed to the emerging grounded theory model.

Appendix I

Example of Selective Coding for the Core Category ‘Connecting with Own Values to Become Resilient’ using NVivo (Release 1.5.2)

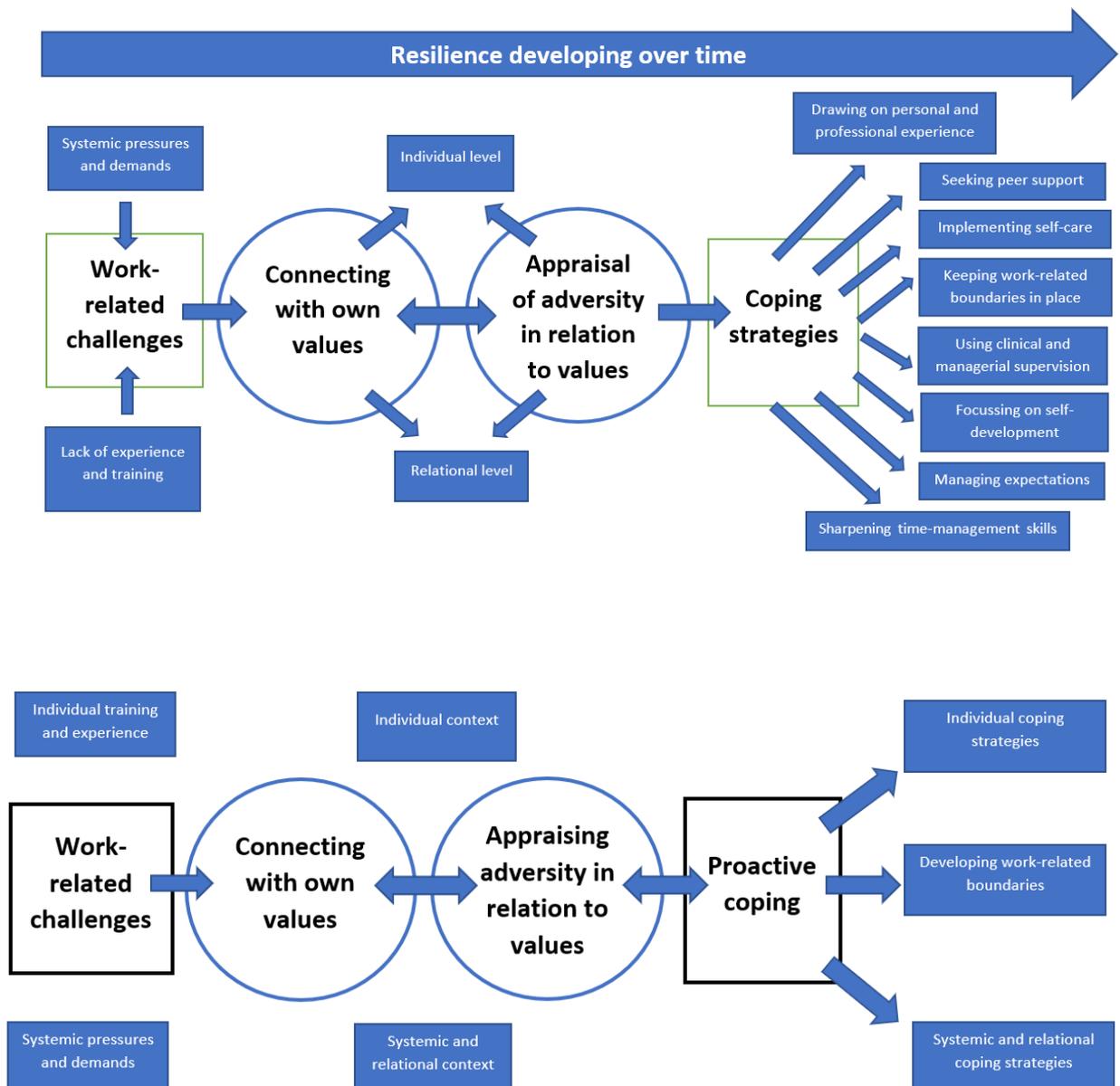
Codes			
Name	Files	References	
Connecting with own values to become resilient	4	4	
Action - Acting in line with values to build resilience	1	1	
Action - Acting in line with work values	2	2	
Action - Being honest with patients as an important value to have	1	1	
Action - Desire of not letting someone down and wanting to support them	1	1	
Action - Focussing on the story, not the scores	1	1	
Action - Helping people, seeing a difference	2	5	
Condition - Stress stemming from not working in line with own values	1	1	
Consequence - Appreciation and enjoyment when you're making a difference	2	4	
Consequence - Feeling energised and alert when supporting clients	1	1	
Interaction - Achieving goal of helping people	1	1	
Interaction - Being raised with a sense of responsibility over your work	1	1	
Interaction - Believing in the work values	1	1	
Interaction - Feeling good about yourself when interventions help clients	2	4	
Interaction - Feeling that all the hard work is worth it	1	2	
Interaction - Manager encouraging the right values and longevity	1	1	
Interaction - Motivation and meaning when feeling needed and helping people	2	2	
Interaction - Offering people the support they need	1	2	
Interaction - Playing a part in someone's journey	1	1	

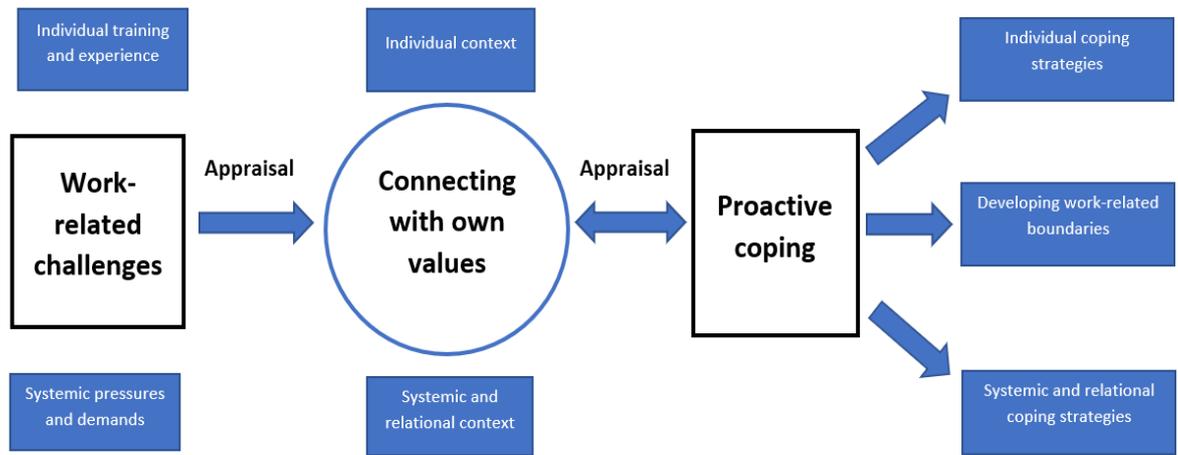
The example above shows the development of the core category ‘Connecting with own values to become resilient’ during selective coding. During this analytical phase the researcher unified all categories under a core category to be able to generate an analytical idea that captured the relationships, interactions and actions between the categories. This process enabled the researcher to develop a core conceptualisation of resilience in PWPs, while taking into account the variation that emerged between categories.

Appendix L

Conceptual Development of Grounded Theory Model of Resilience in PWPs

These below images show how the grounded theory model gradually developed from the data as the analytical process progressed. As data analysis developed, the theory was constantly tested against the data while generating further abstraction and conceptual relationships. The development of the grounded theory model was also regularly discussed and reviewed with the second and third author in research supervision, which promoted further reflection on the data analysis process and the redefinition of the main elements of the model.





Appendix M

Letter from the NHS Research Ethics Committee granting Ethical Approval



Mr Marco Vivolo
 University of East Anglia
 Norwich Research Park, Norwich Medical School,
 Norwich
 Norfolk
 NR4 7TJ

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

09 March 2021

Dear Mr Vivolo

**HRA and Health and Care
 Research Wales (HCRW)
 Approval Letter**

Study title: The process of building resilience in the IAPT
 Psychological Wellbeing Practitioner role: A qualitative
 grounded theory study

IRAS project ID: 292357

REC reference: 21/HRA/0898

Sponsor University of East Anglia

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The "[After HRA Approval – guidance for sponsors and investigators](#)" document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

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

The [HRA website](#) also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **292357**. Please quote this on all correspondence.

Yours sincerely,

Nabeela Gaulton (nee Iqbal)

Approval Specialist

Email: approvals@hra.nhs.uk

Copy to: *Ms Polly Harrison*

List of Documents

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

<i>Document</i>	<i>Version</i>	<i>Date</i>
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [UEA FMH Ethical Approval Confirmation Letter - Amendment Approval 202021-047 (11 Jan 2021)]	Version 2	11 January 2021
Copies of materials calling attention of potential participants to the research [Non-inclusion email to participants]	Version 1	11 January 2021
Copies of materials calling attention of potential participants to the research [Non-inclusion email to participants]	Version 1	11 January 2021
Copies of materials calling attention of potential participants to the research [Email to gatekeepers]	Version 1	11 January 2021
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of Sponsor insurance and indemnity (2 files attached)]	Version 1	24 February 2021
HRA Schedule of Events	1.0	09 March 2021
IRAS Application Form [IRAS_Form_09032021]		09 March 2021
IRAS Application Form XML file [IRAS_Form_09032021]		09 March 2021
IRAS Checklist XML [Checklist_09032021]		09 March 2021
Letter from sponsor [Letter from sponsor]	Version 1	24 February 2021
Organisation Information Document [Marco Vivolo - Organisation_Information_Document_NonCommercial 292357 - Version 2.0 - 23.02.2021]	Version 2	23 February 2021
Participant consent form [MV - Consent Form 23.01.2021 Version 1]	Version 1	23 January 2021
Participant information sheet (PIS) [MV - Participant Information Sheet 11.02.2021 Version 2]	Version 2	11 February 2021
Referee's report or other scientific critique report [Thesis proosal mark and feedback from UEA]	Version 1	06 August 2020
Referee's report or other scientific critique report [UEA FMH Ethics feedback on UEA FMH ethical application]	Version 1	08 December 2020
Research protocol or project proposal [Research Protocol version 3 FINAL 11.02.2021]	Version 3	11 February 2021
Summary CV for student [Summary CV for Chief Investigator (student)]	Version 1	11 January 2021
Summary CV for supervisor (student research) [PF IRAS CV Updated Nov 2020]	Version 1	24 November 2020
Summary CV for supervisor (student research) [JO Research CURRICULUM VITAE]	Version 1	24 November 2020

IRAS project ID	292357
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Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
Single site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organisation Information Document (OID) has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	Appendix 2 of the OID states no funding will be available to sites.	Local collaborator would be expected.	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to hold Letters of Access if focus groups/interviews were held in clinical areas. Letters of Access would not be expected if they were held in non-clinical/administrative buildings.

Other information to aid study set-up and delivery

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

Appendix N

Letter from the UEA FMH Ethics Committee confirming Ethical Approval

Faculty of Medicine and Health Sciences Research Ethics Committee



Marco Vivolo
Norwich Medical School
University of East Anglia
Norwich Research Park
Norwich
NR4 7TJ

NORWICH MEDICAL SCHOOL
Bob Champion Research & Educational
Building
Rosalind Franklin Road
University of East Anglia
Norwich Research Park
Norwich NR4 7UQ
Email: fmh.ethics@uea.ac.uk
www.med.uea.ac.uk

11th January 2021

Dear Marco

Title: The process of building resilience in the IAPT Psychological Wellbeing Practitioner role: A qualitative grounded theory study

Reference: 2020/21-047

Thank you for your email of 15th December 2020 notifying us of the amendments you would like to make to your above proposal. These have been considered and I can confirm that your amendments have been approved.

Please can you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance, and that any adverse events which occur during your project are reported to the Committee.

Approval by the FMH Research Ethics Committee should not be taken as evidence that your study is compliant with GDPR and the Data Protection Act 2018. If you need guidance on how to make your study GDPR compliant, please contact your institution's Data Protection Officer.

Please can you arrange to send us a report once your project is completed.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Jackie Buck', is written over a horizontal line.

Dr Jackie Buck
Chair
FMH Research Ethics Committee

COVID-19: The FMH Research Ethics Committee procedures remain as normal. Please note that our decisions as to the ethics of your application take no account of changes in Government measures and UEA guidelines relating to the coronavirus pandemic and all approvals granted are, of course, subject to these.