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DEPERSONALISATION, BURNOUT AND RESILIENCE AMONG MENTAL HEALTH CLINICIANS

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mental health professionals? A systematic literature review.

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Summary of Major Research Project

Section A

A systematic literature review was conducted in order to assess what factors help to build and maintain resilience from burnout among mental health clinicians. Eleven studies were found to meet inclusion criteria and were therefore included in the review. Currently no large scale quantitative studies have assessed resilience among mental health clinicians. A number of themes such as hope and optimism, team support and self-care have been presented following qualitative investigations. Limitations in current understanding and areas of potential future research are discussed in light of the importance of resilience in maintaining high standards of ethical and effective care.

Section B

This study used a mixed methodology to examine predictors of depersonalisation among qualified clinicians employed in NHS mental health services, as well as an exploration of experiences of resilience. Mental Health Nurses, Clinical Psychologists and Social Workers completed an online survey and open-ended qualitative questions. Multiple regression analysis suggested five significant predictors of depersonalisation. Thematic Analysis of responses to open-ended questions suggested themes of depersonalisation and burnout, as well as resilience. Implications of maintaining compassionate and effective client care in the current economic environment was discussed as well as limitations and areas of future research.

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Major Research Project

Section A

What factors help building and maintain resilience among mental health professionals? A systematic literature review.

Abstract

Previous research has suggested that service users value caring relationships with clinicians. In order for clinicians to maintaining compassionate and caring support for service users, they must be able to remain resilient to the stressors of working in such a role in order to provide ethical and effective care. Despite being a common human trait, resilience has largely been studied in relation to child development following adverse life events. Tis systematic literature review aimed to understand what factors help to build and maintain mental health clinician's resilience to burnout.

Eleven studies were found to meet inclusion criteria, which including; three theoretical papers, three quantitative studies and five qualitative which were therefore included in the study. Currently no large scale quantitative studies have assessed resilience among mental health clinicians. Theoretical papers were analysed for potentially helpful theories regarding resilience. A number of themes emerged such as hope and optimism, team support and self-care as helpful in building and maintaining resilience among mental health clinicians.

Limitations in reliability and validity of current research as well as areas of potential future research discussed explored. Implications for the importance of resilience are discussed with regards to maintaining high standards of ethical and effective care.

1. Introduction

1.1 Resilience, Clinicians and Organisations

Resilience is a common and innate feature of human psychology which most people will experience in their lives (Sheldon & King, 2001). Sheldon & King (2001) describe resilience as an ‘unappreciated magic’, which despite exposure to unfavourable life circumstances, allows us to remain satisfied with our lives. Despite the commonality amongst most people, theory and research regarding resilience has historically been seated within child development, particularly following abuse or negative life events, and psychopathology (Luthar, Cicchetti, & Becker, 2000). As a result of this paradigm of focus, resilience has been considered as something ‘rare or pathological’ (Bonanno, 2004).

In more recent years resilience has been expanded to a greater number of areas of research including human resources, military personnel, and physical chronic illness. These new areas of research however, tend to hold a similar assumption that resilience is ‘abnormal’ rather than Sheldon & King’s (2001) ‘Positive Psychology’ approach of resilience being common and ‘normal’. For this reason, definitions of resilience tend to be focused from a negative psychological perspective. Additionally, due to the inherent nature of resilience being somewhat socially constructed, there is no unified or agreed upon definition of resilience.

The ability to ‘bounce back’ (Pooley & Cohen, 2010) and the ‘adaption to adversity’ (Luthar, et al, 2000) have been largely accepted as defining features of resilience, as well as a consideration for longevity and ‘positive’ social outcomes (Masten, Best & Garnezy, 1990).

Clinicians working in mental health services are likely to encounter adverse experiences for which they too will be required to ‘bounce back’ and ‘adapt to adversity’. Since its introduction in 1948 the National Health Service (NHS) in the UK has provided, free at the point of use, health care for the entire population. This has been provided regardless of the individual’s social status or means and includes mental health care (Webster, 1998). Mental

health services are particularly reliant upon well-trained, available staff (Boardman & Parsonage, 2007). This requires compassionate interpersonal engagement with service users, often conveying emotional and potentially traumatic content, in order to support and promote recovery. If mental health services are to promote interpersonal compassion to their clients, they themselves will need to be the medium for compassion.

Other stressors which might affect clinicians' abilities to remain resilient include the organisations. NHS mental health services have experienced a great number of transformations over recent decades. Most noticeably, this has been the closing of large asylums and the greater emphasis on 'Care in the Community' (The King's Fund, 2014). In 2014 the Coalition government recognised the importance of mental health services in the NHS calling for 'parity of esteem' with physical health services (Department of Health, 2014). Despite this, The King's Fund (2015) reported that just 11% of the NHS budget was spent on mental health services, despite mental health difficulties being responsible for 28% of the total 'burden of disease' in the UK (Mental Health Foundation, 2015). In the financial year of 2014/15 approximately 1.8 million people were in contact with mental health and learning disabilities services in England, with 5.7% of them receiving hospital admission (Health and Social Care Information Centre, 2015). Clearly clinicians working in mental health services are likely to experience exposure to emotional distress and will be working under a number of organisational stressors. In order to provide ethical and effective care, clinicians must remain resilient to such adversity.

Clinicians working in NHS mental health settings may be required to work in environments of high demands, with limited available resources. Albee's 'incident formula' proposes a theory in which emotional difficulties can be facilitated by an unfavourable balance of demand compared to available sources (Gullotta, 1997). Albee's formula considered an

‘incident’ and thus resilience is influenced by both the use of internal and external stressors and resources. A diagram of Albee’s incident formula can be seen below in Figure 1:

Figure 1:

Albee’s Incident Formula (Gullotta, 1997)

$$\text{Incident} = \frac{\text{Organic factors \& stress exploitation}}{\text{Competence, coping skills, self-esteem \& social support}}$$

The formula suggests that organic factors or illness, as well as exposure to stress (as mental health clinicians are likely to be) will increase emotional difficulties. In contrast, feeling competent at work, having coping skills and self-esteem, as well as social support is likely to increase resilience to stressors. Although Albee’s formula wasn’t focused on mental health clinicians, it appears to hold some validity in resilience theory. The strong suggestion behind the model is that resilience is not an inherent internal attribute, but one that can be developed on an individual and systemic level. The model also describes difficulties as an interaction between individuals and their environment such as what might be experienced by a clinician working in NHS mental health services.

1.2 Existing Literature related to Resilience

Conducting a systematic literature review of studies related to resilience amongst individuals with chronic physical illness, Stewart (2011) reported a number of reoccurring themes. These included an internal locus of control helping to promote resilience, as well as self-esteem to help the individual believe they can overcome their difficulties. Related to this was a theme of hope or optimism as promoting the individual’s resilience. Stewart (2011) also suggested

that social support was reported as promoting individuals' ability to remain resilient, despite chronic illness. This suggests that resilience may not solely be an internal state, which lends support to Albee's Incident Formula, in which resilience is both internally and externally located. Stewart's (2011) literature review provides a systematic analysis of factors related to resilience. Although the review uses a different cohort and situational factors to mental health clinicians, it does provide a framework within which resilience can be considered.

Masten (2001) conducted a literature review of developmental psychology studies regarding resilience in children who had experienced adverse life events. The author defined resilience as the positive outcome despite 'serious threat to adaptation or development' (Masten, 2001). The author reports the common themes of caring family or community members as being protective of resilience as well as the individual's cognitive and coping skills. The author also suggests that a positive self-view and 'motivation' to change are protective of resilience. Similar to Stewart (2011) this review also appears to provide support for Albee's Incident Formula in emphasising both the internal and external resources of resilience. These reviews, whilst not specifically related to mental health clinicians' resilience, do provide further insight into the concept of resilience, which may be applicable to the area of mental health.

These studies appear to suggest resilience is supported by an interaction of both the individual and their environment as well as external support. Epstein & Krasner (2013) describe resilience amongst doctors as a means of enhancing quality of care and maintaining the workforce. The authors also consider the role of resilience in a 'community' or team as well as individual clinicians.

1.3 Resilience and Capacity for Care

Despite the 'person-centred' values at the heart of current policies, the potential to violate professional, legal and moral standards of care will always exist whilst working with

potentially vulnerable individuals (Twain, 2008). If clinicians are a 'medium' for compassion, a breakdown in compassion and ethical practice is likely to result in practice and conditions that are detrimental to the service users they are commissioned to care for.

Unfortunately resilience to stressors is not always evident among health care clinicians. The Mid Staffordshire Public Inquiry (Francis, 2013) highlighted unethical patient care in physical healthcare. The inquiry called for the NHS Constitution (2015), which promotes 'respect, dignity and compassion', to be given 'priority of place' in every NHS service user's care, every time (Francis, 2013). Highly unethical practice was also demonstrated in mental health services, including abusive and criminal practices which were documented in Winterbourne View Hospital for people with intellectual and neurodevelopmental disabilities (Department of Health, 2011b). These examples demonstrate that for resilience of clinicians needs to be attended to both on a personal and organisational level, and demonstrates the potential dangers of a lack of resilience amongst clinicians.

Front line clinicians working in mental health, are likely to be presented with a number of ethical, moral and personally challenging situations. Ethical decision-making is likely to be influenced by both the individual and their context, including the culture of the service (Verbeke, Ouwerkerk, & Peelan, 1996). The previous Coalition government therefore, set out a commitment to monitor and regulate current services for ethical practice following the Mid Staffordshire Public Inquiry, through the independent Care Quality Commission (CQC) (Department of Health, 2014).

The wellbeing of mental health clinicians may be particularly vulnerable due to the additional demands of their roles. Clinicians may regularly experience difficult clinicians-service user relationships, difficult interactions with other clinicians, increased risk of physical assault in some settings, lack of positive feedback and low pay (Rossler, 2012). Such stressors can lead to a phenomenon termed 'burnout' which has been defined as when the individual or team

exhibit 'exhaustion, cynicism and inefficacy' (Maslach, Schaufeli, & Leiter, 2001). Within clinical settings, a shared culture of ethical practice and collective experiences of burnout have been negatively correlated (Huhtala, Tolvanen, Mauno, & Feldt, 2015). Burnout has been linked to a number of negative outcomes including less compassionate care towards service users (Pines & Maslach, 1978) and the perception of the clinician being more distant and rejecting of service users (Morse, Salyers, Rollins, Monroe-DeVita, & Pfhaler, 2012). It could be argued that burnout was demonstrated by clinicians in services such as Mid Staffordshire hospital and Winterbourne View hospital.

Research has suggested that service users particularly value the therapeutic relationship with clinicians, emphasising the importance of clinicians providing good communication, cultural sensitivity and non-coercive care (Gilbert, Rose, & Slade, 2008). This is supported by empirical research which suggests that the therapeutic relationship is the main driver behind positive outcomes in mental health, rather than specific models of intervention (Wampold, 2013). Although the relationship between resilience and burnout is not necessarily binary, a lack of resilience to stressors may be detrimental and have a negative impact on the ability to maintain an effective relationship (Holmqvist & Jeanneau, 2006). These factors suggest that there is a clear rationale for building and maintaining clinician resilience. This may help to promote valued, effective and compassionate relationships between clinicians and the service users they seek to support. This also offers a rationale for the promotion of preventative measures amongst clinicians in order to build and maintain resilience, in order to protect clinician from emotional difficulties and service users from unethical, ineffective care.

For the reasons considered, there is a clear rationale for the study of resilience amongst mental health clinicians. This includes both the ethical rationale for promoting clinicians' continued capacity to provide compassionate care of service users, as well as the economic benefits of keeping well trained staff working effectively in public services. This literature

review aimed to examine the findings and limitations of current theoretical and empirical literature regarding what factors are helpful in building resilience among mental health clinicians.

2. Method

A systematic literature search was conducted using the following online databases; PsychInfo, Applied Social Science Index and Abstracts (ASSIA), Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed and The Cochrane Database. Search terms used on the databases were (resilience) AND (mental health OR psychiatry) AND (clinicians OR staff OR practitioners OR nurses OR psychologists OR social workers). Initially PsychInfo returned 148 papers, ASSIA returned 130 papers, CINAHL returned 112 papers, PubMed returned 202 papers and The Cochrane Database returned none.

Of the 592 papers returned, abstracts were read to assess suitability for inclusion in the review. The following inclusion criteria was used:

- Papers included contained theoretical or empirical research regarding the concept of resilience amongst mental health clinicians
- Resilience was considered to be a positive attribute for example the growth, increase or development of resilience (these examples are not exhaustive).

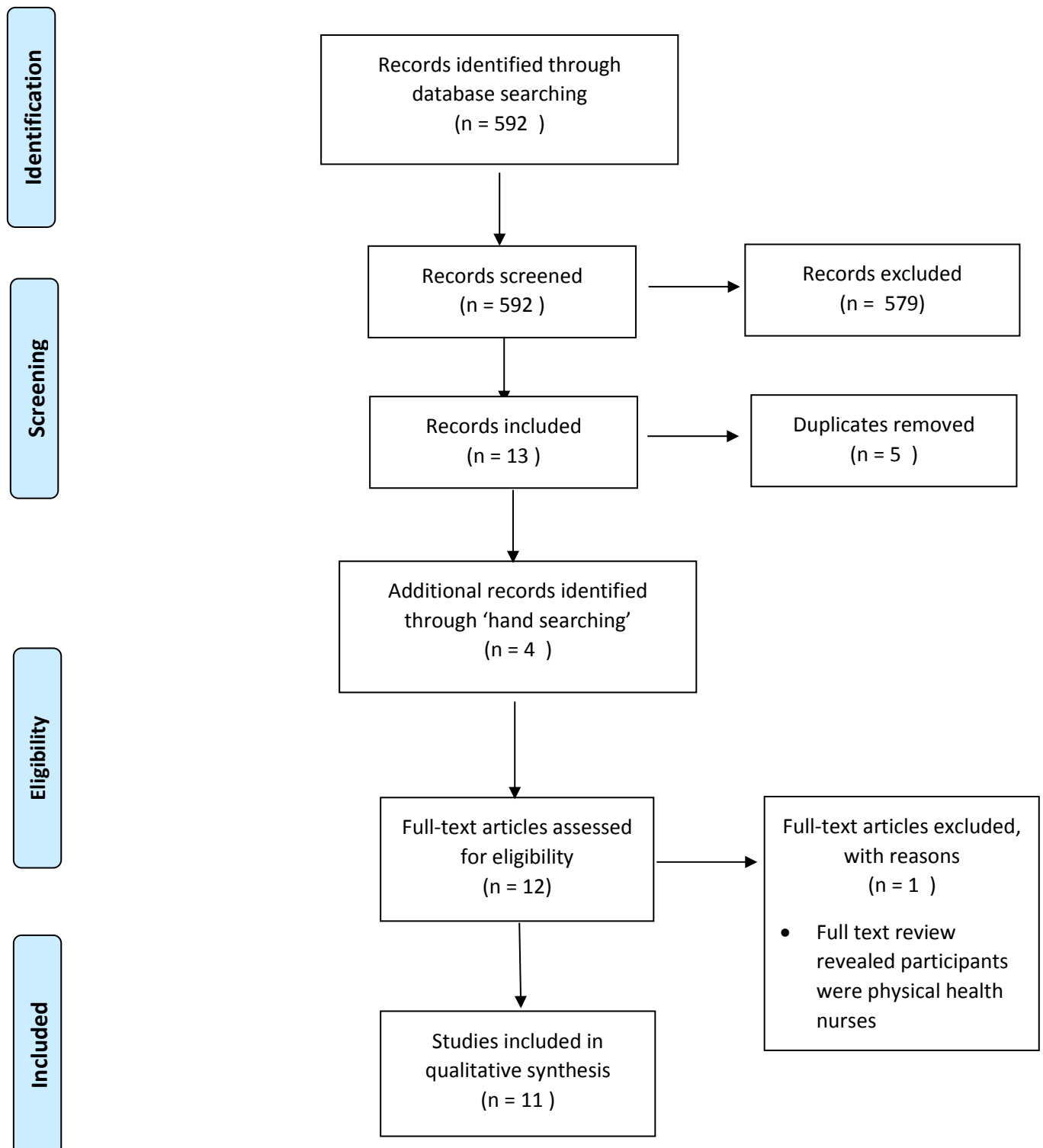
The following exclusion criteria was also applied to papers reviewed:

- If papers examined physical health, or other health care professions outside of mental health
- If papers examined the depletion or lack of resilience (these examples are not exhaustive) which was considered more akin to 'burnout' research than resilience.

From the abstracts reviewed, 579 papers did not meet inclusion criteria. Thirteen papers were identified as meeting inclusion criteria and were accepted for full review. Following the identification of these studies a 'hand search' of reference lists was conducted with a further four papers being identified as meeting inclusion criteria. Upon full review, five articles were duplicates and thus removed. One paper was removed as the research recruited Physical Health Nurses, although had initially appeared to meet criteria as the researchers were Mental Health Nurses. Eleven papers were accepted for full review. Due to a small number of articles meeting criteria, a pragmatic approach was taken to inclusion, in which both theoretical papers were reviewed as well as research papers (including qualitative and quantitative methodologies). A flow-chart depicting the literature review process can be seen below in Figure 2:

Figure 2

A Flow chart depicting the systematic literature review process



3. Literature Review

Following database and hand-searching for relevant papers eleven papers were reviewed in this paper. Of the eleven papers accepted, three were theoretical papers that did not in themselves conduct research, but were related to the relevant subject of this review. Initially theoretical papers were reviewed to help the identification of themes which are later examined in the research papers. Three such papers used quantitative cross-sectional methodologies and were assessed for quality using the Cross-Sectional Studies tool (AXIS) (Downes, Brennan, Williams, & Dean, 2016) (see Appendix A). The remaining five papers used a variety of qualitative methodologies in order to help understand participants' subjective experiences. Qualitative papers were assessed for quality using Mays and Pope's (2000) checklist (see Appendix B). Further themes were identified during the full reading of the research papers. These themes were used to analyse what factors the literature suggests are helpful in building resilience. Table 1 below lists the eleven studies included in the review with an overview of the studies' methodology, main findings and limitations:

Table 1

Full list of the studies included in the review with overview

Author, date and country	No. of participants and methodology	Overview of study	Main outcomes of study	Limitations
Ashby, Ryan, Gray, & James (2013) Australia	N=9 Qualitative, narrative	Study aimed to develop understanding of narratives of resilience for Occupational Therapists working in a mental health	A strong professional identity was reported to be supportive for Occupations Therapists' resilience. This included being seen as a worthwhile and theory driven profession. Social networking and supervision within the profession were also supportive of resilience.	Due to the narrative methodology the study does not seek to be generalisable. It would be helpful to study further the factors identified by participants
Cleary, Jackson & Hungerford (2014) Australia	N/A Theoretical	The paper examined resilience amongst Mental Health Nurses following a the results of a national Delphi study	Study defines concepts of personal, workplace and organisational resilience. Changes in services and legislation have affected nurses' views of their roles. This includes the change allowing Physical Health Nurses to work in mental health settings leading to a loss of Mental Health Nurses' unique identity	The paper presents findings from a previous Delphi study however does not present any of the data from this study despite drawing conclusions.
Collins (2007) UK	N/A Theoretical	The paper examined theories of resilience amongst Social Workers	The paper describes 'resilience' as a common human trait. Organisational structure and rules give greater emphasis to 'the head' over 'the heart' despite the need for emotional connection with clients. The paper suggests that there is a need for support from colleagues and managers with the emotional burden. The article describes resilience as a quality of a social care team as oppose to the individual. The article also proposes; positive reappraisal, goal-directed work and finding meaning (as well as hope) in work as important to maintaining resilience	The paper largely draws upon research from other areas of resilience theory rather than specifically about mental health clinicians. Theories are then generalised to this context.
Author, date	No. of participants	Overview of	Main outcomes of study	Limitations

and country	and methodology	study		
Edward (2005) Australia	N=6 Qualitative, IPA	Mental Health Nurses were interviewed to gain subjective understanding of their experience of resilience working in crisis care.	Participants reported that the team was a protective factor and that self-care, promoted resilience. The following themes were identified as fostering resilience; non-work related support; <i>professional development and insight; humour; sense of faith; expertise and confidence; support at work; separation of work and home life.</i>	The paper offered a limited number of quoted examples from participant interviews. The paper would have benefited from a greater number to gain a better sense of reliability of interpretations.
Frajo-Apor, Pardeller, Kemmler & Hofer (2016) Geographical information not provided	N=61 Quantitative	The study aimed to understand the relationship between mental health professionals in assertive outreach caring for individuals with serious mental illness. Results were compared to a control group of general population.	A positive correlation between emotional intelligence (EI) and resilience was demonstrated, however levels of EI and resilience were not statistically different between the mental health professionals and the control group.	The authors report a possible conflict of interest as their service was linked to the one participants were recruited from which may have increased socially desirable responses to questions.
Harker, Pidgeon, Klaassen & King (2016) Australia	N=133 Quantitative	The study aimed to understand the relationship between mindfulness, resilience and burnout in mental health and allied service clinicians	Data was collected via self-report measures and analysed for predictive relationships. Findings suggest that mindfulness was predictive of clinician resilience. Resilience was predicative of lower levels of burnout. Higher age of clinicians was also found to predict levels of resilience.	The study used self-report data which may have been effected by clinicians answering in a socially desirable manner.

Author, date and country	No. of participants and methodology	Overview of study	Main outcomes of study	Limitations
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Hernandez, Gangsei & Engstrom (2007) Columbia	N=12 Qualitative, Grounded Theory	Mental health clinicians working with individuals who had experienced political kidnapping or violence in Columbia were interviewed. The authors aimed to develop a new 'vicarious resilience' concept	Authors propose the idea of 'vicarious resilience' being a parallel process, learnt from working with clients who describe experiences of being resilience to adversity. The clinicians appeared to develop their hope of sense, fulfilment and longevity having worked with such clients.	The study could be critiqued for offering participants the idea of vicarious resilience and asking their experiences, which could be considered leading. Additionally the construct of 'vicarious resilience' is not well defined.
Lamb & Cogan (2016) UK	N=17 Qualitative, IPA	The study examined mental health clinicians and volunteer mental health clinicians to compare their experiences of resilience.	Coping mechanisms within teams such as humour and professional support were identified. Support, training and being able to use clinical skills was also identified as helping build resilience. The need for time away from work as replenishing resilience was also identified.	The IPA study contained two heterogeneous focus groups and aimed to create theory from findings. This technique is more akin to Grounded Theory than IPA which generally aims to understand subjective experience.
Matos, Neushotz, Quinn-Griffin & Fitzpatrick (2010) USA	N=32 Quantitative	The relationship between resilience and other factors such as job satisfaction were examined with Mental Health Nurses working in inpatient units.	Findings showed a statistically insignificant correlation between resilience and job satisfaction. Pay and schedule were rated as most likely to influence work satisfaction. Perceived status of the professional was correlated with resilience.	The small sample size resulted in some results not being statistically significant. Further analyse on such factors could benefit from larger sample sizes.
Author, date and country	No. of participants and methodology	Overview of study	Main outcomes of study	Limitations
McGee (2006) USA	N=1 Information	Personal reflections and	Author describes resilience as a 'survival skill' where adaption to	The author does not provide

	regarding methodology not given	accounts of resilience amongst working with 'at risk' clients.	circumstances can mean the difference between a 'happy and unhappy' life. The author describes a 'role model' colleague who provided a sense of hope and resilience to the author.	information regarding the specific methodology used to analyse their reflective account. The findings are therefore hard to analyse for reliability and validity.
Sadler-Gerhardt & Stevenson (2012) USA	N/A Theoretical	This paper examined theoretical ideas regarding the impact of potentially traumatic work upon counsellors.	The paper describes the process of 'compassion satisfaction' in which counsellors choose work which will nourish a sense of fulfilment and enjoyment. The paper also promotes 'self-care' including one's own 'spiritual' care.	Whilst the paper draws upon recommendations from other authors, it is not known whether these have been empirically researched or are themselves theoretical.

3.1 Theoretical Papers

Collins' (2007) theoretical paper describes the importance of hope and optimism in building Social Workers' resilience. The authors defines hope and optimism as future based attitudes or affects, of positive goal seeking, although note the lack of research regarding these two constructs. Collins' (2007) describes resilience as a common human trait, citing recovery from bereavement and traumatic life events as examples of where 'most people' will adapt to and 'recover' from such negative life events. The author suggests this may also be a common attribute amongst Social Workers, however this claim cannot be reliably made due to the lack of supporting research. The author presents the idea of hope and optimism and suggests that higher levels of optimism help sustain social workers and provide better outcomes for clients. The author calls for the greater promotion of optimism within Social Worker training and supervision. The paper does not directly examine the relationship between optimism and resilience and therefore is theoretical rather than empirical. The paper is written within a UK

public mental health context, which provides greater validity to other clinicians exposed to similar stressors within UK public health and social care settings.

Cleary, Jackson & Hungerford's (2014) paper theorises Mental Health Nurses' experiences of resilience in Australia. The paper followed a previous Delphi study conducted by (McIlrath, Keeney, McKenna, & McLaughlin, 2010) regarding aspects of effective primary-care services. Cleary et al, (2014) considered the Mental Health Nursing's professional identity in the light of changes to services and legislation. The authors suggested that strong identity was supportive of resilience and helped maintain Mental Health Nurses despite exposure to stressors. One such recent change in practice allowed nurses trained in physical health to work in mental health settings. Participants reported that this could be detrimental to Mental Health Nurses' identity as a unique and skilled profession. Where Mental Health Nurses were more able to maintain their sense of being a unique profession with a specific skill set, Cleary et al (2014) suggest they are more likely to maintain their resilience also.

Sadler-Gerhardt & Stevenson's (2011) theoretical paper proposed a relationship between clinician self-care and maintaining resilience. The paper cites a decrease in resources and increase in demand in USA public health services as being detrimental to clinician resilience. The authors suggest that clinicians do not always allow time for 'fun' and 'laughter', which can promote resilience amongst team members. The authors also suggest physiological factors such as eating well and obtaining enough sleep can help improve resilience, which could potentially be difficult when employed in potentially stressful public mental health services. The paper does not provide any qualitative or quantitative analysis of its own or from other research, therefore it is not possible to assess the reliability of claims made. The theoretical themes identified by the three papers appear to suggest both internal factors, such

as hope and optimism, and self-care as well as external factors such as view of the profession are factors in building and maintaining resilience.

3.2 Empirical Papers

The following section is organised based upon themes presented in theoretical studies and found in empirical studies. This includes both quantitative and qualitative methodologies.

3.2.1 Hope and Optimism. Research has suggested that hope and optimism are factors which service users value in clinicians and are an important aspect of the ‘Recovery Model’ (Borg & Kristiansen, 2004). McGee’s (2006) paper, describes a colleague with whom the author worked, who helped to instil the author’s sense of hope in a setting that appeared at times to be hopeless. This sense of hope was thus transferable to the service users the author sought to support despite their own difficulties, and restriction placed upon the public service. Like Collins (2007), McGee (2006) suggests that resilience is common trait, evident among nurses working in such environments and recalls others’ stories of resilience. McGee’s (2006) paper does not provide a clear exposition of the methodology used to collect and interpret data used in the study. The author provides a personal account of their experience of working with homeless and vulnerable adults, providing physical and emotional support. The paper is qualitative in nature however does not meet many of Mays & Pope’s (2000) quality criteria. The single participant sample does not provide the opportunity for triangulation of data or attention to negative cases that oppose the dominant view.

The implicit suggestion within the paper appears to be that clinicians find strength and support from their colleagues, and presents the idea of a collective resilience among the nursing profession. Due to the personal reflective nature of the paper and lack of clear methodology, it is difficult to have confidence in McGee (2006) findings. The paper does,

however, provide an interesting subjective account about a colleagues' hope building resilience amongst mental health clinicians. There is likely to be strong chance of bias towards McGee (2006) findings as the author is intrinsically linked to the data. As a result McGee's (2006) findings needs to be interpreted with caution, however does provide an interesting account of an important external factor in building resilience.

3.2.2 Professional Identity, Status and Satisfaction. Ashby, Ryan, Gray & James (2013) used a narrative methodology of qualitative research to understand Occupational Therapists' personal stories of resilience. Participants consisted of nine qualified Occupational Therapists who each had a minimum of two years post-qualification experience. Ashby et al (2013) provided a good description of the recruitment process including explanations as to why some potential participants had declined to participate in the study. The authors did not provide an explanation of reflexivity towards bias.

Participants expressed a belief that their profession provided an effective and worthwhile intervention for clients. This belief was supportive of their resilience, although it could fluctuate, contingent upon circumstances and stressors present at that time. Participants in Ashby et al's, (2013) study reported that being able to express Occupational Therapy specific models of intervention, using a rationale based on formulation was protective of their resilience. This skill was reported to aid communication to colleagues and managers about the theory underpinning activities such as 'going for walk' or 'attending a BBQ' with clients. This enabled Occupational Therapist to maintain their professional status as a theory driven and worthwhile profession within mental health services. These findings appear similar to Cleary et al's (2014) theory that Mental Health Nurses' identity as a valued profession was supportive of resilience.

Ashby et al's, (2013) study was conducted in Australia which may be cultural different to UK, however, it does hold similarities in its publicly funded mental health services. Narrative research methods aim to find stories in individuals' subjective life experiences within a social context (Lieblich, Tuval-Mashiach, & Zilber, 1998) and therefore would not aim to be generalisable. It does nonetheless increase knowledge of what might be potentially helpful in building resilience for clinicians similar to the Occupational Therapists recruited for Ashby et al's, (2013) study.

Matos, Neushotz, Quinn-Griffin & Fitzpatrick (2010) conducted a quantitative cross-sectional study of the relationship between job satisfaction and resilience amongst Mental Health Nurses working in inpatient units. The study recruited 32 nurses working in five different inpatient mental health units in the USA. Participants were recruited using an opportunistic sample of nurses at work on the day of study. This creates a potential for bias as participants who are less resilient may have been on sick leave, or have left the service's employment and therefore not included in the research.

Resilience was measured using Wagnild & Young's (1993) Resilience Scale. The measure is a Likert self-report questionnaire which has been widely used and shown to have good reliability and internal consistency (Ahern, Kiehl, Sole, & Byers, 2006). Job satisfaction was measured using The Index of Work Satisfaction (IWS) Part B (Stamps, 1997). The measure is also a Likert self-report questionnaire which has been shown to have good reliability and validity (Zangaro & Soeken, 2005). Age, gender and ethnic data was reported by the authors, and had no bearing upon differences in reported job satisfaction.

Matos et al, (2010) reported a correlation between job satisfaction and professional resilience which was not statistically significant at the generally accepted $p < .05$ level, although was significant at the $p < .10$ level. The non-statistical significance of results suggests that the null

hypothesis, that the correlation is due to chance, cannot be rejected. The authors suggest that this relationship may be worth researching further, possible with a larger sample to power findings. The strongest factor correlated with resilience was job status. A moderate correlation of .45 was reported, which was significant at the $p < .05$ level. The authors suggest that the findings demonstrates that Mental Health Nurses experiencing positive feelings towards their own professional status is helpful in supporting resilience. Generalisability is made difficult by the homogeneity of the participants' work place in inpatient settings. It may be that professional status is more strongly related to resilience in a setting where nurses in particular are potentially more likely to be exposed to stressors such as physical aggression than in other settings.

3.2.3 Resilience within teams. Edward (2005) conducted a qualitative study using an Interpretive Phenomenological Analysis (IPA) methodology. The study recruited six mental health clinicians working in crisis care in Australia, consisting of four Mental Health Nurses, one allied health professional and one medical professional. The study explored clinicians' experiences of resilience in mental health care. IPA methodology seeks to understand the individual's subjective experience, which is explored through the researcher's interpretations of responses (Biggerstaff & Thompson, 2008). The author provides good information about participants included in the study and stated that all potential participants who were approached, agreed to participate in the study. The study provides some possibility of triangulation as three different professions are represented amongst the six participants. They were however, all recruited from crisis care teams in a specific geographical area. Findings from the study may be biased due to the authors also working in the same service. Edward (2005) provides a framework with which the interpretation of data is assessed for 'trustworthiness' although does not outline further methods in which reflexivity is actively incorporated into the process of data analysis.

Edward (2005) describes a theme of participants expressing the importance of the team in maintaining resilience. This can involve debriefing as a team after untoward incidents and through support at work from colleagues. The findings suggest that the participants saw resilience as something that could be built by a team rather than solely an attribute of the individuals within teams. The paper however, only provides a small number of quotations from participant interviews demonstrating this. A larger number of quotations would help demonstrate reliability in interpretations. Edward's (2005) findings support Collins' (2007) paper suggesting that resilience can be built within a team. Collins' (2007) suggests that team based resilience is not a 'static concept', and that changes in working environment and personnel can have an effect on the team's resilience.

Within the context of teams, Lamb & Cogan (2016) interpreted participants' responses as describing the use of 'black humour' in teams to help build resilience amongst colleagues. The study used an IPA methodology recruiting UK mental health clinicians as well as volunteers working in UK mental health third sector organisations. The authors interpreted the professional clinicians and volunteers as describing a theme of support of colleagues within teams as helping in maintaining resilience to stressors. It appeared that for professional clinicians the support was more based on professional practice than for the volunteers who valued social support more strongly. The importance of having a shared team 'value' was also reported by both cohorts as helping to maintain resilience to difficulties. The findings of Lamb & Cogan's (2016) study appears to emphasise the need for clinicians to experience a supportive team in order to maintain resilience. The findings build upon Edward's (2005) findings regarding the importance of teams as well as the use of humour within teams.

Lamb & Cogan's (2016) research was conducted within UK NHS and third sector mental health services which are likely to experience a number of stressors around service provision

and delivery. The study employs an IPA approach, however, data was collected using two separate focus groups of professional mental health clinicians and third sector volunteers. The authors note that the comparison of two groups is ‘unusual’ in IPA research as participants are usually recruited from a homogenous group. The authors aimed to investigate how the participants build and maintain resilience despite work-based stressors (Lamb & Cogan, 2016). The authors’ rationale for using IPA is their desire to understand participants ‘perception and experiences’ (Lamb & Cogan, 2016). IPA research traditionally seeks to find themes from the interpretation of subjective experience (Smith, 2004), rather than the comparison of heterogeneous groups. The interpretation of themes by Lamb & Cogan (2016) are therefore less reliable and need to be considered within a caveat of having an unusual methodological approach. If the authors had sought to create a theory from the comparison of groups, a Grounded Theory approach, where heterogeneous groups can be more easily compared (Flyvbjerg, 2011) may have been more appropriate and provided greater reliability.

3.2.4 Emotional Intelligence. Using a quantitative methodology Frajo-Apor, Pardeller, Kemmler & Hofer (2016) studied the relationship between emotional intelligence and resilience amongst mental health clinicians and the general population. The study recruited participants from Assertive Outreach teams who worked with clients experiencing ‘severe and enduring’ mental health difficulties. The authors do not give details on the geographical location participants were recruited from, however, researchers were based in an Austrian university. The study recruited 61 mental health clinicians and 49 control participants who did not work in mental health. Participants in the experimental condition were matched with control participants for age and gender in order to control for the effects of these variables on resilience and emotional intelligence. The two samples groups were analysed and found to provide similar levels of variance of cognitive-abilities and verbal intelligence to avoid potential for these variable to be confounding. The authors found

differences in levels of education and therefore adjusted to control for this effect, although but do not provide further details regarding this process.

The results of Frajo-Apor et al's, (2016) study found a small positive correlation of .20 between emotional intelligence and resilience which was statistically significant at the $p < .05$ level. The authors suggest that the findings demonstrate that emotional intelligence is related to resilience, although correlational studies cannot show causation. Interestingly the study did not find difference in levels of emotional intelligence or resilience between mental health clinicians and the control group. The authors suggest that, despite their initial hypothesis, mental health clinicians are not more resilient and thus not more protected from stressors than the general population.

The authors suggest from their findings that emotional intelligence training amongst mental health clinicians may be helpful in promoting resilience. The authors' conclusions need to be taken with the caveat that only a small relationship between emotional intelligence and resilience was demonstrated. Additionally, due to the lack of causality, increasing one construct does not necessarily mean the other variable will increase. Data in cross-sectional studies such as Frajo-Apor et al's, (2016) are collected at a single point in time and cannot demonstrate changes over time. The effect of increasing emotional intelligence on resilience could be studied over time using a longitudinal experimental design. Frajo-Apor et al's, (2016) study is also limited by the single sample pool of Assertive Outreach clinicians, which the authors appear to generalised to all 'mental health clinicians'. It may be that in a working in an Assertive Outreach service has particular stressors or benefits that affect resilience, which are therefore not generalisable to other services. Research into other clinical settings such as primary care or specialties such as Child and Adolescent services, may find different ratings of resilience.

3.2.5 Resilience and secondary traumatisation. The concepts of secondary vicarious traumatisation and secondary traumatic stress have been widely used in burnout research. The two concepts define the phenomenon of clinicians exhibiting a range of behaviours akin to compassion fatigue, burnout and post-traumatic stress disorder. Such difficulties can occur following mental health clinicians hearing clients' stories of experiencing trauma and abuse (Baird & Kracen, 2006). Juxtaposed to this, Hernandez, Gansei & Engstrom (2007) proposed the concept of 'vicarious resilience'. The authors propose the theory that working with clients who are resilient following traumatic experiences can build the clinician's resilience too. Hernandez et al, (2007) conducted a qualitative study using Grounded Theory to create a new theory of how mental health clinicians experienced resilience. The study recruited clinicians working in Columbia with victims of political violence and kidnapping.

Of the twelve participants recruited, eleven were psychologists and one was a psychiatrist, working in public and private sector organisations. The authors do not provide details of how many clinicians were approached to participate in the study, or reasons for declining to participate. The authors describe the selection of participants being purposefully based upon the 'intensity and notoriety' of work they were conducting, which in itself could have affected the discourse given space to by participants. Guidelines for 'trustworthiness' of interpretation are referenced including consultation with participants following transcription.

Hernandez et al, (2007) provided a number of quoted examples of where clinicians had reported working with clients who had increased their own sense of fulfilment and regaining of hope. Participants were also reported to have described experiencing a renewed commitment to supporting their clients and the society of which they felt a part of, following the systemic trauma of political violence. The authors suggest that mental health clinicians

can learn coping skills in times of adversity directly from clients' own experiences of resilience. The authors describe 'vicarious resilience' as a 'unique consequence of trauma work' which derives from the empathic connection made (Hernandez et al, 2007). This theory suggests not only can resilience be maintained by mental health clinicians working with traumatised clients, it can be increased.

The implication could be for mental health clinicians to have more variety in caseloads, including working with clients who have themselves been resilience despite adversity. The validity of the findings are limited due to the nuances of Columbia's specific geo-political situation as well as the differences in culture in Latin America compared to western countries. Nonetheless, the theory may have utility for clinicians working with individuals who have survived political violence in other regions who come to the UK, such as asylum seekers and refugees. The findings of the study appear to present a 'clear truth' which does not meet Mays and Pope's (2000) criteria for qualitative studies, in which a wide range of 'truths are incorporated. Grounded Theory, more so than other qualitative methodologies, seeks to create theory from subjective experiences, but which are considered within a social constructionist epistemology (Charmaz, 2008).

3.2.6 Self-care. The idea of intuitive self-care techniques as building of resilience is supported by Edward's (2005) qualitative IPA study of six mental health clinicians in Australia. The author described themes of self-care including exercising, getting good sleep and maintaining hobbies outside of work can help to build and maintain resilience amongst clinicians. The qualitative paper provides only a few examples of quotations from participant's transcripts. Providing a greater number of quotations may help to demonstrate reliability of findings and the phenomenological experience of participants.

Edward's (2005) study supports Sadler-Gerhardt and Stevenson's (2011) theoretical paper regarding the importance of self-care of clinicians working in mental health services. Whilst Edward's (2005) qualitative paper does not in itself seek to provide generalisable data, it does add weight to theoretical claims made as to the importance of self-care in maintaining resilience. It can therefore be deemed as 'relevant' findings which builds upon existing theory. It could be beneficial for researchers to conduct larger scale experimental or cross-sectional research in order to better understand what 'self-care factors' may be helpful in building and maintaining resilience amongst mental health clinicians.

3.2.7 Mindfulness. Harker, Pidgeon, Klaassen & King (2016) conducted a quantitative study of the relationship between resilience and 'mindfulness' amongst clinicians working in mental health and other allied areas such as foster care. The authors acknowledge the increased use and knowledge of Mindfulness techniques and interventions over recent years. Harker et al, (2016) defined mindfulness for the purposes of their study as an 'intentional state of awareness' as opposed to a specific intervention. The study recruited 133 clinicians and aimed to examine predictive relationships between factors related to resilience and burnout. Resilience was measured using the Resilience Factor Inventory (Reivich & Shatte, 2002) and mindfulness measured using the Frieberg Mindfulness Inventory (Walach, Buchheld, Butenmuller, Klienkecht, & Schmidt, 2006).

Harker et al, (2016) reported that resilience was a significant predictor of lower levels of burnout ($p < 0.001$) accounting for 30.4% of variance. The study also suggested that higher levels of mindfulness was a significant predictor of lower levels of distress ($p < 0.001$) as measured by the General Well-being Schedule (GWBS), accounting for 5.2% of variance. The GWBS is a self-report measured aimed at assessing subjective experiences across a continuum of psychological distress and wellbeing (Harker et al, 2016). The results of the

study suggest that mindfulness can help clinicians remain resilient to burnout and distress.

The authors suggest that promoting mindfulness amongst clinicians working in mental health services, could be beneficial in promoting resilience and maintaining high levels of good quality care. Interestingly, the authors found clinician age to be a significant predictor of resilience ($p < 0.01$) although this factor only accounted for 4.7% of variance. Harker et al, (2016) suggest that this could be due to less resilient clinicians leaving employment in mental health services earlier in their careers. The authors acknowledge the potential limitations of using self-report scales as participants may have answered in a socially desirable manner due to the perceived negative implications of low resilience scores.

4 Discussion

4.1 Research Limitation and Implications

Despite its acceptance as a concept in other areas of research, resilience amongst mental health clinicians working in public services, appears to be a relatively new concept in research. This literature review was limited by the relative dearth of research available on this topic, compared to other areas of resilience research. Frequently, research appeared to concentrate on the phenomenon of clinician burnout as opposed to resilience. For this reason any conclusions from this literature review can only be tentatively given. Of the eleven papers presented, only eight were research papers, many of which presented methodological limitations. Currently there are no large scale empirical research studies assessing which factors help to build and maintain resilience amongst a range of mental health clinicians and professions.

A further five studies used qualitative methods which in themselves do not seek to be generalisable 'findings' but could contribute to or expand the area of knowledge. Of the five

qualitative papers, each had relatively small participant samples and did not give space to discourses that opposed the dominant narratives being presented. The five studies included tended to focus upon narratives that were more common and supported pre-existing theories regarding resilience, such as humour, hope and optimism, and self-care. Giving a greater voice to less dominant narratives that emerged in qualitative studies, particularly IPA studies helps give a narrative to subjective experiences. Such narratives may be less commonly reported, but of equal benefit to resilience theory. This could potentially have helped increase trustworthiness in their findings.

Three studies included in the review used quantitative methodologies, however, Frajo-Apor et al, (2016) and Matos et al, (2010) provided some results which were not statistically significant. Authors of such studies tended to over-value results which could have been obtained due to chance. Future research could incorporate larger sample sizes which could potentially provide reliable, statistically significant data as to the relation of specific factors and resilience. Harker et al (2016) offered the largest sample size, however resilience was one of a number of dependent variable analysed. All three quantitative studies were cross-sectional studies and therefore data was collected at one moment in time. This makes findings harder to generalise as they may have been the result of a specific factor that affected them at that time (for example economic or political factors). For greater confidence in findings, data could be collected at several points in time. This would help improve reliability of findings as to whether changing independent variables (such ability to engage in self-care) were predicative of the dependent variable resilience as hypothesised.

Further research is needed in order to help improve understanding of factors that contribute to this maintenance and potentially increase of resilience among clinicians. Future research

could therefore be beneficial for supporting clinicians in maintaining their own being as well as continuing to provide ethical and effective care for the service users.

4.2 Clinical Implications

The papers that were presented in this literature review appear to suggest a range of findings about the nature of resilience amongst mental health clinicians and ways of building and maintaining it. These can include internal factors such as hope and optimism, as well as external factors such as support from colleagues. This appears to concur with Stewart (2011) and Masten's (2001) reviews of resilience in different areas of psychology and healthcare suggesting combinations of internal and external factors as helping to build and maintain resilience. The papers presented in this literature provide a range of domains in which resilience can be built and maintained. This includes individual attributes such as emotional intelligence and interventions that might support this including promotion of self-care, the team and environment clinicians work within, and the potential for growth when working with clients who have experienced trauma.

Lamb & Cogan (2016) appeared to demonstrate the importance of good team support which can be nurtured by teams and services. Throughout the literature included in this review, there appears to be a consistent theme that working in mental health services can be difficult, stressful and potentially lead to burnout. Research across various countries and service settings appears to demonstrate a difficult differential between service demand and available resources. This may be one of an array of factors which influence clinicians' ability to maintain resilience. The sense of support from colleagues might be a factor to consider in future research to add greater depth and understanding to the current literature. Lamb & Cogan's (2016) research was set in UK services and results could provide some understanding of the phenomenological experiences of resilience among qualified clinicians

and trained volunteers in mental health services. The findings suggest that other aspects such as pay and working hours might have less of an impact than support from a team, although generalisable hypotheses can only tentatively be drawn. This theory is supported by work from social psychology emphasising that social relationships are linked to health (Cohen, 2004). The colleagues clinicians work with may have an important effect on their mental and physical wellbeing (Sani, 2012) and thus resilience. This team resilience may be an area of potentially future research. The findings of such a study may be helpful in thinking about team based interventions for promoting resilience, particularly for those who work in challenging environments.

In addition to personal and systemic attributes, Hernandez et al, (2007) appeared to demonstrate a meta-psychological gain from working with individuals who had experienced trauma. The concept of ‘vicarious resilience’ appeared to show clinicians can indirectly gain resilience from clients’ own stories of resilience. Although the research was conducted in a vastly different cultural and political climate, their study suggests that clinicians may be able increase resilience from hearing difficult and traumatic experiences.

5 Conclusions

This literature review aimed to improve understanding of factors that the current literature suggests, helps to build and maintain resilience among mental health clinicians. From the currently available literature it is difficult to provide a definitive understanding of such factors, due to the relative dearth of research and methodological limitations of research available. Some factors and themes, both internal and external to the clinician have been identified. These include both the personal wellbeing of clients, support from colleagues and working environment as well as well as clinicians’ potential for growth amongst the difficult task of supporting those in emotional distress. This also supports the use of Albee’s Incident

Formula (Gullotta, 1997) in future theorising of resilience among mental health clinicians, which also includes both internal and external factors as contributing to resilience and burnout.

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Major Research Project

Section B

Depersonalisation and burnout among UK NHS mental health clinicians: A mixed method study.

Abstract

Burnout in human services has become a widely researched psychological concept over the last 40 years (Shaufeli, Leiter & Maslach, 2009). Negative outcomes of clinician burnout in mental health services is well documented, however less research has focused on the specific burnout subsection of depersonalisation (Maslach, 1998). A mixed methodology was used

which aimed to examine predictors of depersonalisation among qualified clinicians employed in NHS mental health services, as well as an exploration of experiences of resilience and burnout.

A total of 261 Mental Health Nurses, Clinical Psychologists and Social Workers employed in NHS mental health services completed an online survey and open-ended qualitative questions. Multiple regression analysis suggested five significant predictors of depersonalisation; clinicians' specialties, years of experience post-qualification, exposure to physical abuse, emotional exhaustion and low ratings of personal achievement. No significant differences of depersonalisation were reported among different professions. Thematic Analysis of responses to open-ended questions suggested that a 'love of the job' or desire to 'help service users' supported resilience. Job stressors such as exposure to physical abuse or bullying were reported as detrimental to resilience. Implications for maintaining compassionate and effective client care were discussed as well as limitations and areas of future research.

1. Introduction:

Over the last forty years, the concept of 'burnout' has become an extensively researched psychological concept (Schaufeli, Leiter, & Maslach, 2009). Research has spanned a number

of countries and sectors including educational professionals, emergency service workers and health care clinicians (Maslach, 2003). Burnout has been defined as an extended response ‘to chronic emotional and interpersonal stressors’ in an occupational setting and is characterised by ‘exhaustion, cynicism and inefficacy’ (Maslach, Schaufeli & Leiter, 2001). It has also been considered as a response or defence to job stressors, particularly when job demands outweigh resources available to the employee (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001).

Burnout amongst mental health clinicians has been widely researched since the 1970s, where a range of negative outcomes due to experiencing burnout have been demonstrated, including increased levels of sick leave and high turnover (Felton, 1998). Additional to the economic impact amongst healthcare clinicians, burnout may be detrimental to the care clinicians provide to service users. Mental health clinicians experiencing burnout may exhibit less compassion in their care towards service users and can report feeling less successful in their work (Pines & Maslach, 1978). Clinicians may appear more distant or rejecting of clients when experiencing burnout (Morse, Salyers, Rollins, Monroe-DeVita, & Pfhaler, 2012).

Burnout may also have a detrimental effect on the clinician’s personal life, where alcohol misuse (Fagin, Carson, Jeary, De Villiers, & Bartlett, 1996) and substance abuse (Maslach, et al., 2001) may be more common. Within healthcare in general, clinicians may also experience their own mental health difficulties including depression and anxiety, as well as sleep difficulties and psychosomatic pain (Morse et al, 2012)

There appears to be a vast literature regarding the potential negative consequences of burnout among healthcare workers. The Maslach Burnout Inventory (MBI) has been widely used in such studies to measure levels of burnout among employees in various sectors. The measure consists of three subsections; emotional exhaustion, depersonalisation and reduced personal

accomplishment (Maslach, 1998). Maslach (1998) described depersonalisation as the ‘interpersonal dimension’ of burnout, which may be of particular importance when considering the impact of burnout in mental health settings. The Human Service Survey (MBI-HSS) was specifically designed to quantitatively measure the experiences of healthcare and public sector workers.

Menzies (1960) examined the defences physical health nursing staff and trainees employ to avoid being exposed to the anxiety that is experienced through the interpersonal relationships of caring for others. Menzies (1960) formulated the findings within a psychodynamic framework to describe the depersonalisation of service users by nursing staff. Observations included referring to service users not by name, but by their bed number or ailment and having specific jobs that avoid treating individuals as a whole. Menzies (1960) suggested that this allowed clinicians to defend themselves from relating interpersonally with patients whilst providing care. Bain (1998) further describes organisational defences such as depersonalisation as an unconscious response to the ‘anxiety of the primary task’ of caring for individuals in physical or mental distress. The author suggests that such defences are employed by ‘teams’ rather than individuals as observed by Menzies (1960).

Menzies-Lyth (1990) hypothesised that the function of depersonalisation was in protecting the clinician from experiencing ‘full person-to-person relationships’. This enabled the clinician to not view service users as whole persons, thus protecting the clinician from experiencing the anxiety of difficult emotions that caring for others could provoke. These could include such emotions as ‘pity, compassion, love and guilt’ (Menzies-Lyth, 1990). Despite protecting the clinician from these emotions, depersonalisation has been considered to be unhelpful for service user care as well as the clinician’s own wellbeing (Amstrong & Rustin, 2015).

Jackson, Schwab & Schuler (1986) consider a certain level of depersonalisation as ‘helpful’ for some professionals such as those in health care, by enabling the clinician to continue working effectively with many different service users. The authors also noted however, that at extremes, depersonalisation can be detrimental to service users. Wright & Bonett (1997) considered depersonalisation as an unconscious attempt by the clinician to minimise the effect of ‘emotional resource loss’ which can result from emotionally connecting with service users. The authors suggest that depersonalisation may be protective of overall job performance, and functions as a way of maintaining clinicians’ ability to continue practicing in difficult settings. This view of depersonalisation as a means for clinicians to protect themselves from ‘intense emotional arousal’ is supported by Maslach, et al, (2001). The authors however, also reported that excessive depersonalisation appeared to correspond with ‘callous and dehumanised’ responses from clinicians towards service users.

Taken to an extreme, Menzies’ (1960) observations of the potential for clinicians to depersonalise service users, was evidenced in the Mid Staffordshire NHS physical health hospital. Service users were routinely left in soiled bed sheets for hours and not always given access to food and water (Francis, 2013). Unethical and depersonalised practice became commonplace amongst clinicians and management at the Mid Staffordshire hospital (Francis, 2013).

In UK NHS mental health services, demand has outweighed the financial resources made available to mental health services (The King’s Fund, 2015). The imbalance of demand could lead to clinicians working in environments which are under increased pressure to provide care that is not adequately resourced. Although this could potentially lead to positive outcomes such as increased clinician efficiency, it may also be a considerable stressor for clinicians.

Aiming to understand the relationship between different healthcare professions and burnout, Ben-Zur & Michael (2007) studied Clinical Psychologists, Mental Health Nurses and Social Workers employed in mental health services in Israel. Using the MBI-HSS, the results demonstrated no statistically significant differences between levels of emotional exhaustion and personal accomplishment among the three professions. Levels of depersonalisation were however significantly lower among Clinical Psychologists than Mental Health Nurses and Social Workers. The authors suggest that Clinical Psychologists were less likely to depersonalise service users than their colleagues, despite otherwise similar levels of burnout. The study suggests that the interpersonal relating and depersonalisation of service users by clinicians may be experienced differently among different professions.

Ben-Zur & Michael's (2007) study did not account for differences in working environment, job role and demands, resources available, work hours and pay, and other demographic details which may affect clinician's ability to remain resilient to depersonalisation. Burnout research in healthcare suggests that a number of these factors can affect the rates of burnout amongst clinicians. Schaufeli (2007) proposed a number of factors that may contribute to burnout among healthcare clinicians. The author suggests that years of experience is negatively correlated with burnout, suggesting that clinicians who have been qualified longer may be more resilient to burnout. This could potentially be accounted for by 'survival rates'. This theory suggests clinicians who have become burnt-out no longer remain in services, or the profession and thus were not included in data collection for studies such as Schaufeli's (2007).

Schaufeli (2007) also suggests that job stressors such as workload, or perception of the organisation may affect the rates of burnout among clinicians. Additionally the author suggests that 'specific job stressors' may increase rates of burnout amongst clinicians. Schaufeli's (2007) study included physical health clinicians and cited proximity to death as a

one such specific factor. This could however be generalised to other specific factors such as being subjected to bullying at work, threats of or actual physical abuse and unwanted sexual attention at work.

The concept of 'resilience' to burnout and depersonalisation has been considered as a means of maintaining ethical and personal care in mental health services. Although generally used within developmental psychology (Luthar, Cicchetti, & Becker, 2000), the concept of resilience has begun to be more considered in terms of burnout in organisational settings. No clear definition of resilience has been agreed upon, however in this context, the term is usually used to refer to an ability to 'bounce back' (Pooley & Cohen, 2010) or 'adapt to adversity' (Luther et al., 2000). Resilience has been increasingly researched amongst physical and mental health clinicians. Resilience may be considered an opposite state to burnout and depersonalisation and suggests the maintenance of ethical and effective care.

Research regarding service user perspectives on clinicians has emphasised the value placed on the therapeutic alliance with clinicians (Gilburt, Rose, & Slade, 2008). Difficulties in interpersonal relating may affect the clinician's ability to build and maintain that alliance alongside their client, particularly if the clinician is depersonalising a client. Values such as; compassion, respect and dignity, and commitment to quality of care are enshrined in the NHS Constitution and should 'underpin everything' the NHS and its employees seek to achieve (Department of Health, 2012). Clearly if compassionate and ethical practice is to be provided for those experiencing mental health difficulties, the clinician must be the medium through which the service provides compassion to the client. The depersonalisation of service users by clinicians however, may lead to detachment, cynicism and potentially callous, unethical treatment (Maslach, 1998), as well as ineffective care.

Much of the previous research regarding burnout and depersonalisation has largely been focused on a positivist approach, aimed at understanding relationship between various factors and burnout. This has included research using well established quantitative measures such as the Maslach Burnout Inventory (Maslach, 1998). Such research aims to understand the aetiology and resulting outcome of depersonalisation. In recent years, qualitative research has become more common place in healthcare offering a richer narrative of research (Mays & Pope, 2000). Such qualitative research may hold particular utility in depersonalisation research which inherently contains a phenomenological element to it.

Although burnout research regarding healthcare clinicians is common, there is a dearth of research regarding the specific subsection of depersonalisation and potential risk factors, particularly amongst mental health clinicians. This is despite the clear rationale for clinicians to maintain person-centred care to provide ethical and effective practice. This need has been echoed by recent government and stakeholder organisational policies in promoting personalised care in which the service user is viewed as an individual holistic person (Department of Health, 2014; Mental Health Taskforce 2016; NICE, 2011). Due to the lack of existing research regarding mental health clinicians' experiences of burnout and depersonalisation, it would be helpful to assess specific factors that may be linked to this phenomena. Furthermore the qualitative experiences of individual, groups or systems related to burnout and depersonalisation within NHS mental health services have not been systemically researched. As a result qualitative research may hold utility in helping to develop understanding of depersonalisation of clients by mental health clinicians.

For the reasons stated there is a clear rationale for studying the differences in levels of depersonalisation amongst mental health professional groups in order that best-practice can be promoted between clinicians and professions. Previous burnout research suggests a number of other factors may also be related to clinicians' depersonalisation of clients.

Research using both quantitative techniques to assess prevalence and correlated factors could help improve knowledge in this area. Furthermore quantitative analysis may help to inform understanding of phenomenological and systemic experiences of burnout and depersonalisation.

This study aims to further understand prevalence of burnout and depersonalisation as well as variables that are may be predictive of depersonalisation among mental health clinicians in NHS settings. Furthermore, the study aims to understand clinicians own subjective experiences of working in services and depersonalisation in order to develop understanding in this area. The rationale provided is that increasing knowledge of burnout and depersonalisation may help to inform understanding of how clinicians can be better supported to provide person-centred, ethical and effective care for mental health service users.

1.1 Hypotheses

- 1) Clinical Psychologists demonstrate lower reported rates of depersonalisation than other professions working in NHS mental health settings.
- 2) Demographic factors such as ‘years of experience’, ‘speciality’ and area of employment’ are predictors of reported ratings of depersonalisation.
- 3) Specific job stressors such as; exposure to bullying, physical abuse and unwanted sexual attention are predictors of reported ratings of depersonalisation.
- 4) Clinicians’ ratings of overall job stress and perception of their employment organisation is predictive of reported ratings of depersonalisation.

The null hypothesis that any results found are due to chance. The null hypotheses will be rejected if statistically significant results can be demonstrated.

2. Method

Previous research regarding burnout in healthcare have been largely quantitative, however the study of depersonalisation amongst NHS mental health clinicians appears to be a somewhat new area of research. Tashakkori & Creswell (2007) suggest that the use of mixed methods in research helps to address concerns of both the ‘philosophical’ and ‘technical’ concerns of the generation of knowledge. In this study a mixed method approach allows for a broader range of enquiry. A positivist approach was used to aid understanding of prevalence and factors related to depersonalisation, such as profession, demographic data or job stressors.

Additionally this was augmented by the inclusion of a Thematic Analysis of clinicians’ responses. Thematic Analysis can be employed both from a realist, or constructionist epistemology (Braun & Clarke, 2006) to give a broader understanding of burnout among mental health clinicians. The study was therefore conducted using a mixed quantitative and qualitative methodology of inquiry.

2.1 Participants

The study aimed to recruit qualified clinicians working in NHS mental health services, in order to improve understanding of what factors may influence reported rates of depersonalisation and resilience. An online survey was used to collect data from a wide range of participants. Following Ben-Zur & Michael (2007)’s study, Clinical Psychologist, Mental Health Nurses and Social Workers working in mental health settings were identified as potential participants. This study, however aimed to understand the experiences of both female and male clinicians as opposed to Ben-Zur & Michael (2007) which only included female clinicians.

The study was conducted via an online survey and therefore was not restricted to a specific geographical location or service. Participants were made aware of the research by one of two means. Firstly potential participants known to the author were approached and given

information about the study and asked to pass on the information to others who may meet inclusion criteria. This technique is referred to as a ‘snowballing’ technique, which can potentially increase participants sample size, although provides a non-stratified sample. Secondly interest groups were approached on social media with requests to post information about the study in there groups. Potential participants were then able to access further information and the online study should they wish to (see Appendix C). In total 411 potential participants read further information about the online study, of which 261 completed varying amounts of the online survey. No tangible incentive was offered to individuals who participated in the study.

2.1.2 Sample Demographics. In total N= 261 participants participated in the online survey. Demographic information for participants is presented below in Table 2 and sample sizes for independent variable is presented in Table 3:

Table 2

Demographic information collected for participants

Demographic	Category	Frequency (%)
Profession	Mental Health Nurse	174 (67)
	Clinical Psychologist	79 (30.3)
	Social Worker	7 (2.7)
Gender	Female	234 (89.7)
	Male	24 (9.2)
	Transgender or non-binary	2 (0.8)
	Prefer not to say	1 (0.4)
Ethnicity	White (including Irish or other White background)	250 (95.8)
	Asian/Asian British	4 (1.5)
	Black (including African, Caribbean and Black British)	4 (1.5)
	Other ethnic group	2 (0.8)
	Prefer not to say	1 (0.4)
Specialty	Adult Mental Health	158 (60.5)
	Child and Adolescent Mental Health	51 (19.5)
	Older Adult Mental Health	40 (15.3)
	Intellectual/Learning Disabilities	10 (3.8)
Service Setting	Primary Care (Community, Tier1/2)	44 (16.9)
	Secondary Care (Tier 3)	119 (45.6)
	Inpatient (Tier 4)	95 (36.4)
Years of	0-5 years	120 (46)
Experience (post-qualification)	6-10 years	49 (18.8)
	11-15 years	38 (14.6)
	16 or more years	53 (20.3)

Table 3

Sample Size for Dependent Variables

Independent Variable	Category	Frequency (%)
Exposure to unwanted sexual attention (last 12 months)	Daily	5 (1.9)
	Weekly	16 (6.1)
	Monthly	6 (2.3)
	A few times	60 (23)
	No	140 (53.6)
Exposure to threats of physical abuse (last 12 months)	Daily	23 (8.8)
	Weekly	26 (10)
	Monthly	11 (4.2)
	A few times	83 (31.8)
	No	84 (32.2)
Exposure to physical abuse (last 12 months)	Daily	14 (5.4)
	Weekly	20 (7.7)
	Monthly	13 (5)
	A few times	46 (17.6)
	No	134 (51.3)
Exposure to bullying (last 12 months)	Daily	4 (1.5)
	Weekly	15 (5.7)
	Monthly	8 (3.1)
	A few times	48 (18.4)
	No	150 (57.5)

2.2 Materials

2.2.1 Maslach Burnout Inventory – Human Services Survey. Participants were required to complete an online version of the Maslach Burnout Inventory – Human Services Survey (MBI-HSS) which aimed to measure the three constructs within burnout, including depersonalisation. An online license was purchased via the copyright holder Mind Garden in order to reproduce the MIB-HSS online. The MBI-HSS is a 22 question, seven point Likert scale in which participants are asked to select responses to statements about their experience of clinical work in relation to burnout (see Appendix D). The measure reports individual's subjective experiences and responses are based on how frequently statements appear relevant to them. The MBI-HSS has been demonstrated to have good reliability of .70 and higher in healthcare studies (Poghosyan, Aiken, & Sloane, 2009). The measure has been demonstrated to have good validity and ability to differentiate clinicians experiencing burnout from those who are not (Schaufeli, Bakker, Hoogduin, Schaap, & Kladler, 2001).

2.2.2 Copenhagen Psychosocial Questionnaire II – Short Version. Participants were also asked to complete an online version of the Copenhagen Psychosocial Questionnaire II - Short Version (COPSOQ) (Kristensen, Hannerz, Hogh, & Borg, 2005) which aimed to measure a range of subjective experiences of employees (see Appendix E). Although less widely used in mental health settings than the MBI-HSS, the COPSOQ has been used to research clinicians' experiences of employment in physical health settings (Anderson et al., 2014; Kersten, et al., 2014; Nielsen, Yarker, Randall & Munir, 2008). Permission to reproduce the COPSOQ survey online was granted by the copyright holders, the National Research Centre for the Working Environment, Denmark. For seven of the eight scales within in the COPSOQ have been demonstrated to show good reliability of .70 or higher with the eighth scale 'mutual trust' between employees and employer demonstrating reliability of .64 (Thorsen & Bjorner, 2009). The measure has also been shown to demonstrate validity in

predicting employee mental health difficulties and lack of vitality in work (Burr, Albertsen, Rugulies, & Hannerz, 2010).

2.2.3 Qualitative open-ended questions. Participants were given the opportunity to provide written responses to five open-ended questions regarding their ‘wellbeing’ during the survey (see Appendix F). Prior to the beginning of data collection, feedback was received from two clinicians who met inclusion criteria to assess the validity and appropriateness of potential open-ended questions. Positive feedback was received and the questions were subsequently included in the online survey.

2.3 Procedure

Upon accessing the online study potential participants were directed to an information sheet giving details about the study rationale, inclusion and exclusion criteria, and requirements of the participants. Information regarding the favourable ethical approval received for the study was also provided. Participants were also provided with the researcher’s contact details should they wish to ask further questions. All participants received the same information and completed the survey individually. Information about the study and what participants would be required to do was given transparently. No attempts were made to deceive potential participants, who were required to provide informed consent before beginning the survey (see Appendix G).

The study proposal was scrutinised by the Salomon’s Ethics Panel and received favourable ethical approval (see Appendix H). Participants were informed that they were free to withdraw from the study at any point whilst completing it, and could ask for their data to be removed at any time. Participants were also given details of who to contact should they have any further questions or complaints following the study. Participants were informed that they would not be required to provide their name, location or service name in order to protect their

anonymity. In total participants were informed that the survey would take no longer than 30 minutes to complete. Any potentially identifying information in the qualitative responses to open-ended questions such as names of services has been changed to protect the participants', clients' and services' anonymity.

2.4 Analysis

2.4.1 Quantitative. The study employed a cross-sectional design which aims to provide a representation at a 'point in time' of a specific construct (Mann, 2003). In this study the dependent variable of examination in the study was clinicians reported rates of depersonalisation, measured using the MBI-HSS. A multiple regression was conducted in order to establish predictors of depersonalisation amongst clinicians. ANOVA's were conducted to compare means of multiple variables to test the assumptions of the hypotheses and statistical significance of findings.

Power calculations were conducted in order to estimate the required sample to conduct a multiple regression. The analysis suggested that using fourteen predictors, a total sample size of 74 participants would be required with a $p=.05$ confidence interval.

2.4.2 Qualitative. A qualitative Thematic Analysis was conducted using Braun & Clarke (2006)'s six phase technique for the written responses to open-ended questions on the online survey. Thematic Analysis is a widely used qualitative methodology which allows the identification and analysis of patterns (Clarke & Braun, 2013). Due to this study being driven by hypotheses derived from existing literature, a deductive (theoretical) approach was used. This 'top-down' approach enables the coding of responses to appropriate pre-existing themes based on theory (Braun & Clarke, 2006). The technique includes: Familiarisation with the data; Coding the data; Searching for themes; Reviewing themes; Defining and naming themes, Writing up (Braun & Clarke, 2006).

3. Results

3.1 Quantitative Analysis

3.1.1 Ratings of depersonalisation among different mental health professions.

Different mental health professions were compared in order to assess reported rates of depersonalisation. MBI-HSS depersonalisation scores range from 0-42 with lower scores being desirable showing lower rates of depersonalisation of clients. Mean scores were compared for the three professions included in the study; Mental Health Nurses, Clinical Psychologists, and Social Workers employed in NHS mental health services which can be seen in Table 4:

Table 4

Mean Ratings of Depersonalisation by Profession

Profession	N	Mean	Std. Dev.	Std. Error
Mental Health Nurses	169	10.88	7.45	0.57
Clinical Psychologists	76	9.08	6.36	0.73
Social Workers	7	9.71	5.02	1.90

The mean rates of depersonalisation among these professions were within the ‘moderate-level’ of depersonalisation range. Differences between professions were not statistically significant ($p=.18$) suggesting that any differences between professions was the result of chance. As a result Hypothesis 1; Clinical Psychologists report lower rates of depersonalisation of clients cannot be proven as the null hypothesis could not be rejected.

3.1.2 Predictors of depersonalisation. A simultaneous multiple regression was conducted in order to examine which variables were predictive of depersonalisation.

Simultaneous multiple regressions are a useful strategy in investigating multiple predetermined independent variables (Gray & Kinnear, 2012). Overall the regression model was statistically significant ($p < .001$) and accounted for 56% of depersonalisation variance ($r^2 = .56$). Differences between r^2 and adjusted r^2 were .03 suggesting that if results were derived from the population rather than a sample there would be approximately 3% variance in scores (Field, 2009). A Durbin-Watson score of 1.99 was reported suggesting there was no autocorrection errors in the regression and that adjacent residuals were unrelated (Field, 2009). Multicollinearity test suggest that the predictors included in the regression were not correlated. Collinearity VIF Scores of < 10 were reported and collinearity tolerance scores of > 0.2 were reported which are both desirable results.

Normality of the dependent variable depersonalisation, was assessed through analysis of residuals. The frequency histogram and normality distribution plot suggested that data is normal distributed and therefore results can be generalised to a larger population. Having met all the assumptions the results of the regression are presented below in Table 5:

Table 5

Predictors of Depersonalisation

Independent Variable	Standardised Coefficient	Significance
Profession	-.20	.71
Specialty	-.14	.02**
Service setting	-.03	.55
Years of experience	-.15	.00**
Sexual harassment	-.10	.08
Threats of physical abuse	-.11	.27
Exposure to physical abuse	.17	.05**
Exposure to bullying	.02	.72

Emotional exhaustion (MBI)	.60	.00**
Personal accomplishment (MBI)	-.15	.01**
Work environment (COPSOQ)	.02	.81
Employment organisation (COPSOQ)	.05	.43
Work/life balance (COPSOQ)	-.40	.62
Wellbeing (COPSOQ)	-0.5	.42

** = statistically significant at $p < 0.05$ level

The results of the multiple regression analysis show a five independent variables are significant predictors of depersonalisation. These include; speciality (i.e. adult, child etc), years of experience post-qualification, exposure to physical abuse, emotional exhaustion and personal accomplishment.

The results of the multiple regression provided partial support for Hypothesis 2 as some demographic differences such as specialty and years of experience are significant predictors of ratings of depersonalisation. Partial support is also provided for Hypothesis 3 in which the specific job stressor; exposure to physical abuse, was a significant predictor of ratings of depersonalisation. Other stressors such as perceived bullying and exposure to unwanted sexual attention did not appear to predict depersonalisation. Perceptions of the work environment, employment organisation and work-life balance were not statistically significant predictors of depersonalisation. As a result Hypothesis 4 cannot be proven as the null hypothesis that results were due to chance cannot be rejected.

A stepwise forward regression was conducted with the same variables to analyse the extent to which the statistically significant variables predicted depersonalisation. A stepwise multiple regression will only include significant predictors, in order of their predictive value (Field, 2009). The following results can be seen below in Table 6:

Table 6

Stepwise Regression of Predictive Variable

Independent Variable	Standardised Coefficient	Significance
Emotional Exhaustion	.64	.00
Personal Accomplishment	-.17	.00
Years of experience	-.16	.00
Specialty	-.14	.00

The results suggest that 64% of the models predictive value is accounted for by emotional exhaustion. This suggests a strong predictive relationship between MBI-HSS ratings of emotional exhaustion and depersonalisation.

3.1.3 Ratings of depersonalisation dependent on specialty. Further analysis was conducted to compare mean ratings of depersonalisation by clinicians employed in different specialties using an ANOVA. The results can be seen below in Table 7:

Table 7

Mean Ratings of Depersonalisation by Specialty

Specialty	N	Mean	Std. Dev.	Std. Error
Adult	152	10.86	7.27	0.59
Child and Young Persons	50	8.98	6.64	0.94
Older Adults	38	9.71	7.43	1.21
Intellectual Disabilities	10	10.50	5.21	1.65

Within all specialties, mean ratings of depersonalisation were within the 'moderate' range.

Differences between specialties was not statistically significant ($p=.40$) suggesting that any differences between groups was the result of chance.

3.1.4 Ratings of depersonalisation dependent of length of experience. An ANOVA was used to analyse the difference in means for different lengths of experience post-qualification. The results can be seen below in Table 8:

Table 8

Mean Ratings of Depersonalisation by Years of Experience

Years of Experience	N	Mean	Std. Dev.	Std. Error
0-5 years	117	10.91	7.58	0.70
6-10 years	48	10.60	6.82	0.95
11-15 years	34	10.53	7.07	1.21
16+ years	52	8.37	6.06	0.84

Within all ranges of years of experience, mean levels of depersonalisation were within the ‘moderate’ range. Differences between specialties however were not statistically significant ($p=.19$) suggesting that any differences between groups was the result of chance.

3.1.5 Ratings of depersonalisation dependent on exposure to physical abuse.

Exposure to physical abuse was also a significant predictor of depersonalisation of clients. An ANOVA was conducted to analyse clinician’s ratings of depersonalisation based on the frequency of their exposure to physical abuse over the previous twelve months. The results can be seen below in Table 9:

Table 9

Mean Ratings of Depersonalisation by Exposure to Physical Abuse

Exposure to Physical Abuse	N	Mean	Std. Dev.	Std. Error
Daily exposure	14	9.86	7.11	1.90
Weekly exposure	20	14.65	8.33	1.86
Monthly Exposure	13	13.85	8.62	2.39
Occasional exposure	46	10.74	7.13	1.05
No exposure	134	9.66	6.82	0.59

The results of the ANOVA were statistically significant ($p=.02$) suggesting that differences in mean were not due to chance. The means ratings of depersonalisation were in the ‘moderate’ range for the following groups; no exposure to physical abuse, occasional exposure to physical abuse and daily exposure to physical abuse. Mean ratings of depersonalisation in weekly and monthly exposure to physical abuse groups fell within the ‘high’ range of depersonalisation. The results of post-hoc analysis suggest that significant differences were demonstrated between ratings of depersonalisation by clinicians who reported weekly exposure and no exposure to physical abuse ($p=.03$). The results suggest that clinicians exposed to weekly physical abuse report significantly higher ratings of depersonalisation of clients than those who report no exposure to physical abuse in the previous twelve months. Additionally, there were no significant differences between those who reported no exposure to physical abuse and those who reported daily exposure ($p=1$). The results suggest that clinicians who were exposed to physical abuse daily, did not report significantly different

ratings of depersonalisation than those not exposed to physical abuse. The lack of significant data between conditions may have been the result of small sample sizes and relatively large standard deviation within less populated groups. Although participants reporting daily exposure to physical abuse reported lower average rates of depersonalisation, these were not statistically significant from other conditions with higher means such as weekly exposure to physical abuse ($p=0.3$) and may therefore be due to chance.

3.2 Qualitative Analysis

A Thematic Analysis was conducted using qualitative responses to open-ended questions that participants had completed within the online survey. The themes of depersonalisation and resilience were used deductively in relation to the four hypotheses (see Appendix I). Results show that themes of burnout, depersonalisation and resilience did not appear unique to any specific professions, specialties or length of experience.

3.2.1 Themes related to profession. Themes of resilience and depersonalisation among clinicians responses were analysed in relation to how their specific profession affected their experiences. One clinical psychologist reported ‘I love being with people and feel that my role as a clinical psychologist... is valued’. A Clinical Psychologist with between 11-15 years of experience wrote ‘Working with older people and hearing their stories’ when asked what about the profession supported their resilience. Similarly a newly qualified Mental Health Nurse reported ‘The positive effect I have on children’ maintained their wellbeing.

Clinicians also reported how their specific profession could make resilience harder to maintain, for example a Clinical Psychologist of 16 or greater years of experience reported that the specific role meant a ‘Lack of promotion opportunities’ made it harder to maintain resilience to burnout. Demands placed upon specific professions were acknowledged by a Mental Health Nurse with 10-15 years of experience reported ‘The little resources nurses

have' a challenge to maintaining resilience. Another Mental Health Nurse of 16 or greater years of experience reporting 'Mental health nursing in 2016 is simply too much demand' as challenging their ability to remain resilient.

3.2.2 Themes related to demographic difference. Clinicians' demographic differences were also acknowledged in qualitative responses. A Mental Health Nurse of between 6-10 years of experience reported that the 'low wage compared to the responsibility I carry' made it harder to maintain resilience. A Clinical Psychologist of the same number of years of experience wrote 'Having enough financial security to know I can leave' helped maintain their wellbeing. Specific stressors such as perceived bullying from colleagues or management was identified as a theme that could make maintaining wellbeing more difficult as well as physical abuse from service users. This appeared to mostly be reported by Mental Health Nurses and may be that their specific job role leads to a greater exposure to physical abuse, compared to Clinical Psychologists and Social Workers employed in mental health services. Two Clinical Psychologists with 16 or more years of experience reported that 'losing client(s)' to suicide had had an impact upon their ability to maintain their resilience to depersonalisation.

3.2.3 Themes related to specific job stressors. Participants' responses to qualitative questions also provided themes of resilience and depersonalisation in relation to general job stressors and perceptions of the organisation. Themes of resilience included a newly qualified Clinical Psychologist writing 'maintaining a work-life balance' as being helpful and a newly qualified Mental Health Nurse stating that '...receiving psychological support through staff wellbeing service' had helped maintain their resilience to burnout. Across professions, several participants reported a 'love of the job' or a desire to 'help service users' was protective of burnout and helped maintain their resilience despite stressors. Organisational

factors such as difficult ‘management demands’ or ‘reduced budgets’ across professions was reported as being detrimental to resilience.

3.2.4 Themes related to general job and organisational stressors. Clinicians also reported how the effects of burnout may be detrimental to their ability to remain resilient and avoid depersonalisation of clients. A Clinical Psychologist of 11-15 years of experience wrote ‘When feeling worn out and stressed it’s hard to be present in the moment with the client’. A Mental Health Nurse of between 5-10 years of experience stated that ‘If I am under stress – I cannot give my best’. Finally a theme of being overwhelmed by the job and this being related to depersonalisation was found. A Mental Health Nurse of 16 years or greater experience wrote ‘‘I think they and the team got the best of Me but left nothing for me, my family and friends’.

4. Discussion

The results of this research suggest factors such as the specialty mental health clinicians are employed in and years of experience post-qualification are significant predictors of lower rates of depersonalisation amongst participants. Comparing means within these variables presented no significant differences in mean ratings of depersonalisation for different specialities and clinicians’ years of experience. Exposure to physical abuse was also a significant predictor of depersonalisation. Those who were exposed weekly, rated levels of depersonalisation significantly higher than participants who are never exposed to physical abuse, although also those who reported daily exposure to physical abuse. The hypothesis that demographic details such as the speciality clinicians were employed in was a predictor of depersonalisation was supported by this research. Further research is needed to ascertain where these differences lie and what factors influence this variable. The hypothesis that

specific stressors, such as exposure to physical abuse is predictive of depersonalisation was also supported by this study.

The hypothesis that Clinical Psychologists demonstrate lower rates of depersonalisation than Mental Health Nurses and Social workers employed in mental health settings could not be proven. These results were opposed to Ben-Zur and Michael (2007)'s study which demonstrated significantly lower rates of depersonalisation amongst Clinical Psychologists. Ben-Zur and Michael (2007) recruited comparable number of participants (N=249) however only recruited female clinicians and was conducted in Israel. Difference in results may be attributable to the different demographic of participants, or cultural differences amongst the participant sample and services participants were employed in.

The additional two subsections of the MBI-HSS, decreased emotional exhaustion and increased personal accomplishment, were predictive of lower rates of depersonalisation. This suggests the subsections of the MBI-HSS are reliable constructs and can be used to predict clinician depersonalisation of clients. This appears to lend support to Maslach & Jackson's (1981) findings of a significant correlation of .40 ($p < .01$) between colleague ratings of fellow clinicians' emotional exhaustion and the clinician's subjective rating of depersonalisation and emotional exhaustion. This suggests that emotional exhaustion may be noticeable amongst colleagues who could potentially have an important role in the safeguarding of clients from the potential of depersonalised care. This also supports previous research conducted by Leiter and Maslach (1988) who proposed a hierarchical progression of the three subsections of burnout. The authors suggested that individuals experience emotional exhaustion which leads to the depersonalisation of clients and subsequently a diminished sense of personal accomplishment.

4.1 Research Limitations and Implications

The study employed a cross-sectional study design to examine UK mental health clinician's experiences of depersonalisation and resilience. Research into the area of clinician depersonalisation would benefit from a longitudinal design in which participants' self-report measures and potentially objective measures of burnout could be collected over time. This would allow greater reliability in findings as effects of changing variables such as years of experience or job stressors which effect individuals could be measures and controlled.

Additionally, participants who subsequently chose to leave NHS mental health services could still participate in order to understand their perception of burnout at different points. The difficulty with a longitudinal study is that factors such as funding for services could change over time. This may result in reported rates of depersonalisation changing due to an confounding variable, rather than those measured, reducing the reliability. This current study is limited by relationships between variables and depersonalisation cannot be considered causal due to results being collected at one moment in time.

Comparison of means was conducted using ANOVAs which generally are robust against violations of assumptions of homogeneity. Nonetheless, substantially uneven group sizes between groups can cause the significance level to be inaccurate and therefore undermined (McGuinness, 2002). The null hypothesis could therefore be falsely rejected. Uneven group sizes was seen in data collected for this study, for example Social Workers accounted for 2.7% of the sample compared to Mental Health Nurses who represented 67% of the sample. Consideration as given to non-parametric alternatives such as Bartlett's and Cochran's test, however these in themselves may be problematic considering the dependant variable; ratings of depersonalisation, demonstrated homogeneity of variance (McGuinness, 2002). Future research would benefit from stratified sampling techniques in order to equally distribute sample sizes across independent variable groups.

The study was also limited by a participant sampling bias in which a convenience sample was used, recruiting current NHS mental health clinicians. This sample will potentially increase validity as the sample represents those in NHS mental health services, however, does not include the perspectives of clinicians who no longer work for services. Some of these individuals may have experienced burnout and subsequently decided not to work in NHS services, or have left their profession altogether. This limitation is acknowledged by Schaufeli (2007) and termed the 'survivor rate' and may well be a confounding variable in this study as well. These potential participants could have provided valuable insight into depersonalisation and factors which may influence the development of burnout if they have had personal experience as such. The research focused however on current employees as loss of such employees could represent a potential economic loss through training, continued professional development and other publically funded expenses. Additionally employees who have remained in NHS services despite stressors may be able to provide insight into resilience to burnout and the avoidance the depersonalisation of clients.

The study may have also experienced participant bias as those who decided to participate may have felt a desire to express their experiences of difficulties working in NHS mental health services. Others who experienced less difficulties working in this area may have felt more ambivalence about participating, therefore creating another sampling bias. Attempts to control for this were made by asking clinicians about their 'wellbeing'. This term was considered more neutral and potentially would allow participants to considered responses across a range of states of wellbeing, either positive or negative. Using terms such as 'resilience' or 'burnout' may have primed participants to respond only to their experiences of those specific emotional states.

Although recruiting similar sample sizes to previous studies, this study may have experienced some non-significant findings when comparing demographic means due to small sample sizes

in particular groups. During recruitment, Social Workers employed in NHS mental health settings appeared more difficult to identify and recruit. This may be due to smaller numbers of Social Workers employed in services compared to Mental Health Nurses and Clinical Psychologists. Additionally Social Workers may experience a unique or specific set of constraints upon their resources causing potential participant's to feel they were unable to participate.

Other smaller sample groups included those employed in Intellectual/Learning Disabilities services which may represent smaller clinical teams, and those who have between 11-15 years of experiences. Increasing sample sizes across different groups within variables may have helped to aid the detection of significant differences between clinician's ratings of depersonalisation. The sample provided validity for professions recruited for the study, however it cannot be generalised to further professions employed in NHS mental health services. This includes Psychiatrists, Psychotherapists and non-clinical management who will have their own experiences of burnout and resilience.

This research was largely focused upon 'observable' demographic variables and self-reported perceptions of the workplace environment. The study is limited as it did not consider personal factors that may affect depersonalisation and resilience. Mitchell and Hastings (2001) suggest that clinicians' use of coping strategies was predictive of lower rates of burnout among those working in Intellectual/Learning Disability services. Further research into effective personal coping strategies could be helpful in understanding resilience. Qualitative analysis also appeared to present abstract personal factors such as a 'love of the job' or the specific demographic of clients they worked with as promoting resilience. Future research in identifying individuals' experiences and creating theories around what factors help clinicians remain person-centred and ethical in their care would be beneficial.

This research was also limited by the fact that depersonalisation was considered amongst different areas of mental health such as speciality or setting, however did not consider experiences within specific clinical teams. Burnout may be more common in some teams and less common in others (Schaufeli, 2007). Menzies (1960) observed a clinical team unconsciously employing the defence of depersonalisation, rather than a subset of clinicians

It may be that clinician's individual experiences of depersonalisation are more closely related to that of the team experience. Buunk & Schaufeli (1993) suggest that burnout may be a 'contagion' in which team members model colleagues' observable experiences of burnout, for example the depersonalisation of clients. This theory suggests that a team's dynamics and ways of functioning may be more important in understanding clinicians' experiences of depersonalisation. Future research may therefore benefit from studying the relationship between individual and team experiences of depersonalisation.

4.2 Practice Implication

The study provided findings that may have some implications for healthcare providers, management and clinicians working in NHS mental health settings. The findings suggest that in this study, different professions did not demonstrate different ratings of depersonalisation. As a result the findings of the study may therefore be better understood on an individual or environmental level. The study suggests that weekly exposure to physical abuse was likely to predict depersonalisation of clients by participants. The results further suggest that participants who reported weekly exposure to physical abuse, reported significantly higher levels of depersonalisation than participants not exposed to physical abuse. This appears to fit with Isaksson, Granheim, Richter, Eisemann & Astrom (2008) who studied exposure to physical abuse among care home workers. The study reported a 'vicious cycle' where staff who were regularly exposed to physical abuse reported greater levels of burnout. This in turn

influenced their communication with residents of the care home increasing further risk of physical abuse towards care home staff. These results do however need to be interpreted tentatively as there were no significant differences between participants who reported daily exposure and no exposure to physical abuse, which does not appear to fit with previous research. Potentially participants may be experiencing a resilience or desensitisation to physical abuse when experiencing it daily, however results were not statistically significant and therefore may be the result of chance.

The results of this study could therefore have implications for supporting those who are regularly exposed to physical abuse to maintain high levels of care, as well as recognising potential signs of burnout. This is important for both the client care and helping reduce repeat risk of physical abuse. Further research with larger sample sizes would also be helpful in providing further understanding as to why participants reporting varying frequencies of exposure to physical abuse may have reported different rates of depersonalisation of clients.

Across all demographics, depersonalisation of clients appeared to be evident among the clinicians who participated in this study. Although this only represents an average and can be effected by outliers, the results suggest that the participants who are employed in NHS mental health services, may experience moderate-high levels of depersonalisation and burnout. This was also supported by qualitative responses, some of which appeared to contain narratives of depersonalisation of clients and burnout by participants. The results of the study suggest that a greater emphasis could be placed on assessment and intervention for those experiencing burnout. This could be important in both retaining clinicians who have trained or received public funding, as well as helping to maintain compassion and appropriate care for clients.

Although generalisation can only be made tentatively the results of the study, including participant responses, suggest that there may be a rationale for further research, with larger

sample sizes. This could help to develop understanding of burnout interventions for mental health clinicians. Additionally clinician's experiences of resilience to burnout despite difficulties should be shared and encouraged, as some participants in this study reported an ability to carry on despite adversity.

5. Conclusion

The results of the study add to knowledge and understanding of factors related to reported rates of clinician depersonalisation, as well as experiences of resilience in NHS mental health settings. Although the results should be interpreted cautiously, this study provides some qualitative and quantitative support for the phenomena of depersonalisation. Participants appeared to demonstrate this across a range of demographics included in the study. Further research is needed in order to understand the experiences of other professional groups as well as what person factors may contribute to depersonalisation or resilience to this phenomena.

Understanding these concepts could be vital in order to maintain clinician wellbeing and thus protect clients from depersonalised, ineffective and unethical care. This is of particular importance in the current economic climate in UK public services. Austerity measures have led to a reduction of expenditure on NHS mental health services (The King's Fund, 2015) despite an increased demand upon these resources (Mattheys, 2015). Compassion is a part of the care that needs to be supported and promoted (Spandler & Stickley, 2011). The NHS Constitution (Department of Health, 2012) describes the need for clinicians to respond with 'humanity and kindness' to individuals' 'pain and distress'. The results suggest further research is needed particularly at this time to provide further understanding of potential interventions to support clinicians. This is important to avoid losing the valuable resource that clinicians represent and to maintain high levels of ethical care for those who are in need of NHS mental health services.

6. References

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Part C**Appendix A**

AXIS Cross-Sectional Studies tool (Downes, Brennan, Williams, & Dean, 2016)

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Appendix B

Qualitative Quality Assessment Tool (Mays & Pope, 2000)

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Appendix C

Copy of participant information which appeared at the beginning of the online survey

Hello. My name is Stephen Wright and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study regarding the wellbeing of mental health staff working in the NHS. Before you decide it is important that you understand why the research is being done and what it would involve for you.

The purpose of the study is to understand mental health professions experiences of working in the demanding climate of NHS mental health services. The findings of the study may be used to better inform service management and providers about how mental health clinicians can be better supported.

Do I have to take part?

It is up to you to decide to join the study. If you wish to take part you will be asked to tick the box on the next page to provide your consent. You are free to stop doing the survey at any point, without giving a reason. If you want your data to be removed from the study, please let me know by emailing me at:

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Please let me know the date on which you began the study and the response to your 'favourite animal' question so that your data can be identified and removed.

What will I have to do if I take part?

Participating in this study will involve completing a survey which should take no longer than 30 minutes. The survey will ask you questions about your workplace environment and wellbeing as well as your views about working with mental health service users. You will also be asked to provide demographic information and data and typed responses to questions in the survey may be used and quoted in the study write up. All data will be anonymous and you will not be asked to disclose your name, where you work or any other information that may identify you or your employer. Data will be securely stored on an encrypted data stick and then securely destroyed after 10 years.

If you have any questions or concerns, before, during or after completing the study please email me at the above address. I will be happy to answer any questions you may have.

Who is organising and funding the research?

I will be organising this research which is funded by Canterbury Christ Church University as part of my Clinical Psychology training.

Who has reviewed the study?

The study has been reviewed by Canterbury Christ Church University's ethics committee and received favourable ethical approval. My project is supervised by Information removed from electronic copy (Clinical Psychologist and Joint Clinical Director at Salomon's Centre for Applied Psychology)

Appendix D

Copy of the Maslach Burnout Inventory – Human Services Survey (MBI-HSS) used in the online survey

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Appendix E

Copy of the Copenhagen Psychosocial Questionnaire II – Short Version included in the online survey

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Appendix F

Copy of open-ended questions used in the online survey

1. What helps you to maintain your wellbeing at work and keep you going?
2. What makes it harder to keep going and maintain your wellbeing at work?
3. How do you think your personal wellbeing affects the way you work with service users?
4. What do you like most about your work?
5. What aspects of your work do find most challenging?

Appendix G

Copy of participant consent form included in the online survey

Consent to take part

Please click where promoted below to confirm consent

1. I confirm that I have read and understood the information provided for this study. I have had the opportunity to consider the information, ask questions and have them answered satisfactorily
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected
3. I agree that anonymous quotes from open-ended questions I have completed may be used in published reports of the study findings
4. If you wish to take part please click to confirm your consent to do so

Appendix H

Copy of ethics approval letter



Salomons Centre for Applied Psychology

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Dear Stephen,

Depersonalisation of clients amongst mental health professionals in NHS adult mental health services

Outcome: Full Approval

The panel would like to thank you for your submission and we are pleased to offer you approval for your proposed study. The panel had some observations for you to consider with your supervisor and to report back for our records:

1. Section 8, number of participants at Part A 165, and also stating 55 per group. Please clarify the numbers.
2. Section 11, 'discomfort or distress': the direction here to participants seems more than might be reasonably necessary (for example ringing 999). Please consider this with supervisor and consider what could be reasonably suggested without alarming anyone (perhaps an organizational service is available?).
3. Appendix 3 – 1st Question states 'helps/enables' – please clarify and decide what the phrase will be.
4. Appendix 4 – Needs proof reading: the 2nd paragraph needs to be rephrased and the last sentence could be explained better. Under 'do I have to take part' – please see second sentence and revise. There is a word missing in sentence 'the data you have provided....'.
5. Appendix 5 – Consent form: omit phrase 'medical care or legal' and just state 'without affecting rights'. Look at numbering.
6. Patient Information Form – needs proof-reading.
7. Information Sheet should have information about data storage.

The panel would also like to recommend that personal professional indemnity insurance is seriously considered, as institutional and employer insurance primarily aims to cover the employer and/or institution.

Yours sincerely,

A handwritten signature in blue ink, appearing to read "Margie Callanan".

Professor Margie Callanan
Chair of the Salomons Ethics Panel

Appendix I

Example of responses to open-ended questions and deductive analysis of themes of depersonalisation and resilience based on hypotheses

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Appendix J

Letter to the chair of the Salomon's Ethics Panel following completion of the study

To the chair of the Salomon's Ethics Panel,

I am writing to inform you that I have now completed the data collection and write-up of the study regarding depersonalisation and resilience among NHS mental health clinicians, for which you granted me favourable ethical approval. Burnout and depersonalisation, which is a subset of burnout, has been demonstrated to have detrimental effects for both clinicians and the service users they seek to help. This study used a mixed methodology to examine what factors predicted reported ratings of depersonalisation, including different mental health professions reported ratings of depersonalisation, as well as experiences of resilience. In total 261 clinicians participated in the study including, 174 Mental Health Nurses, 79 Clinical Psychologists and 7 Social Workers employed in NHS mental health services. Participants completed an online survey measuring reported ratings of burnout (including depersonalisation) and experiences of job stressors.

A multiple regression was conducted which suggested five significant predictors of reported ratings of depersonalisation. These included; the specialty clinicians work in (i.e. Adult, Child & Adolescent), years of experience post-qualification, exposure to physical abuse, high ratings of emotional exhaustion and low ratings of personal achievement. No significant differences were reported among different professions ratings of depersonalisation. A Thematic Analysis of responses to open-ended questions suggested that a 'love of the job' or a desire 'to help others' was supportive of resilience to burnout. Job stressors such as exposure to physical abuse or bullying were reported as being detrimental and a factor in feeling burnout.

The results have implications for mental health services in helping clinicians remain resilient in order to maintain high levels of effective and ethical care. Compassionate care is a key part of the NHS Constitution, however this may be more difficult for clinicians to convey when experiencing burnout, and in particular depersonalisation. The results have particular importance for services where exposure to physical abuse is more common. Post-hoc analysis suggest clinicians who are exposed to physical abuse at work on a weekly basis report significantly higher ratings of depersonalisation than those who are not exposed. Emotional exhaustion was the most significant predictor of depersonalisation, and it may be that this phenomenon is easier for clinicians and managers to notice among their colleagues compared to depersonalisation. This suggests a possible target group for potential interventions.

Further research is required in order to understand individual differences which may affect reported rates of depersonalisation and resilience, such as personality and coping strategies which was not included in this research. Additionally factors such as team dynamics and support may have an effect on clinicians' ratings of depersonalisation and resilience. Future research would also benefit from examining potentially helpful interventions for clinicians reporting experiences of depersonalisation and burnout.

If there is anything else you would like to know about the study or have any other questions, please feel free to contact me.

Kind Regards,

Stephen Wright

Clinical Psychology Trainee

Appendix K

Letter to participants who requested information upon completion of the study

Dear <insert participant name>,

Thank you for expressing an interest in receiving information about the study you participated in regarding NHS mental health clinicians' wellbeing and experiences of burnout. In total 261 clinicians participated in the study which aimed to understand more about predictors of depersonalisation, which is a part of burnout, and personal experiences of resilience and burnout. Burnout and depersonalisation has been demonstrated to have a detrimental effect for both the clinician and service users. It appears however, that a number of clinicians appear able to maintain resilience and continue working in effective and person-centred way.

The results of the study suggested that there were five significant predictors of clinicians' ratings of depersonalisation. These included; the specialty clinicians work in (i.e. Adult, Child & Adolescent), years of experience post-qualification, exposure to physical abuse, high ratings of emotional exhaustion and low ratings of personal achievement, however average scores for all three professions included in the study (Mental Health Nurses, Clinical Psychologists and Social Workers) were all in the 'moderate' range of depersonalisation. No significant differences were reported among different professions ratings of depersonalisation. Analysis of responses to open-ended questions suggested that a 'love of the job' or a desire 'to help others' was supportive of resilience to burnout. Job stressors such as exposure to physical abuse or bullying were reported as being detrimental and a factor towards feeling burnout.

The results could have implications for services where exposure to physical abuse is more common. Post-hoc analysis suggest clinicians who are exposed to physical abuse at work on a weekly basis report significantly higher ratings of depersonalisation than those who are not exposed. Emotional exhaustion was the most significant predictor of depersonalisation, and it may be that this phenomenon is easier for clinicians and managers to notice among their colleagues compared to depersonalisation. This suggests a possible target group for potential interventions.

I would like to thank you again for taking time out of your busy schedule to participate in this study, it really is appreciated. I plan to submit my findings for peer-review in a published journal so that the results can be shared more widely. If you have anything further you would like to ask or have any observations, please do not hesitate to contact me on the below email address.

Kind Regards,
Stephen Wright
Clinical Psychology Trainee

Appendix L

Journal Publication Information

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