COMPASSION SATISFACTION, COMPASSION FATIGUE, BURNOUT, AND SELF-CARE AMONG SOUTH AFRICAN CLINICAL AND COUNSELLING PSYCHOLOGISTS: A CROSS-SECTIONAL MIXED METHODS STUDY

by

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This study is dedicated to all psychologists who have braved the depths of their own as well as others' despair.

PLAGIARISM DECLARATION

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I, Elsemarié van der Walt, declare that this dissertation is my original work except where I have used or quoted another source, which has been acknowledged. I further declare that the work I am submitting has never been submitted before for another degree to any other university or tertiary institution for examination.

SIGNATURE

12 February 2021

DATE

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ABSTRACT

Psychologists are a scarce resource in South Africa, making a high rate of retention to the profession vital. In addition, psychologists carry the ethical responsibility to provide a high standard of mental health care to their clients, some of whom may be traumatised as a result of the high local crime rates. Exposure to client trauma, distress, and suffering may impact psychologists' own wellbeing and their functioning as therapists. The concept of professional quality of life contrasts the positive (compassion satisfaction) and negative (compassion fatigue and burnout) outcomes experienced from doing therapeutic work. Self-care may play a role in mitigating the negative and enhancing the positive outcomes.

This study aimed to compare levels of compassion satisfaction, compassion fatigue, burnout, and self-care among South African clinical and counselling psychologists with varying years of experience. Furthermore, it aimed to investigate relationships among these variables and to attain a better understanding of the interrelations through qualitative data.

This sequential explanatory mixed methods study assessed compassion satisfaction, compassion fatigue, burnout, and the frequency of applying self-care practices among clinical and counselling psychologists who practice in South Africa. The instruments used in the quantitative assessment were the ProQOL-21, the Copenhagen Burnout Inventory, and the Self-care Assessment for Psychologists. Relationships between the assessed constructs and biographical aspects were explored and compared for early, mid and late career groups. Compassion satisfaction was negatively associated with compassion fatigue and burnout ($p < .01$). Significant inverse relationships were found between self-care and the negative outcomes, while compassion satisfaction was positively correlated with self-care ($p < .01$).

MANOVA results indicated that significant differences exist between the late and early career group in terms of compassion fatigue, compassion satisfaction, and burnout (p

< .05). Significant differences were also evident between the mid and late career groups for compassion fatigue, personal burnout and work-related burnout ($p < .05$).

Results from standard multiple regression analyses indicated that overall burnout, personal, work-related, and client-related burnout can significantly predict compassion fatigue.

The subsequent qualitative phase explored the experiences of two psychologists from each career stage to enhance the interpretation of the quantitative data. The three themes identified by using thematic analysis were challenges of being a psychologist, rewards of being a psychologist, and self-care facets. Participants explained facing both regulatory issues and occupational challenges such as seasonal fluctuations and administrative tasks. Other challenges related to their clients and the experience of the negative effects from their work. The rewards of being a psychologist was found to flow from therapy outcomes and their attitude towards the profession. Participants reported applying self-care within time constraints both proactively and reactively. Details of work-related self-care and personal self-care depended on individual preferences.

The professional quality of life of South African psychologists was found to be significantly influenced by a complex interaction of career stage, self-care, challenges, and rewards. Training programmes for psychologists should include awareness of the work-related and client-related challenges, recognising the experience of the negative effects, implementing self-care practices, and introductory trauma therapy training. Psychologists should also be motivated to maintain career-long self-care and support from colleagues to enable them to provide ethical care to their clients.

Keywords*: compassion satisfaction, compassion fatigue, burnout, self-care, clinical psychologist, counselling psychologist, trauma therapy.*

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: INTRODUCTION TO THE STUDY

1.1 Introduction

This chapter presents the background to the study, outlining the setting in which South African psychologists provide therapy. It features local crime figures, subsequent traumatisation of the population, the limited number of registered psychologists, and the impact of providing trauma therapy. This is followed by a discussion of the research problem. Then results from relevant local and international studies, constructs describing the functioning of psychologists, and the importance of self-care are highlighted. The aim and objectives of the study are subsequently described, followed a chapter outline and conclusion.

1.2 Background of the Study

South Africans experience high crime rates: 601,366 contact crimes – which include 20,336 murders – were reported in the 2017/18 financial year (SAPS, 2018). This translates into an estimated 1,042 contact crimes per 100,000 of the population (Statistics South Africa, 2018a). Household crimes affected an estimated 1,545,701 (7.5%) of South African households during this period, and individual crimes affected an estimated 1,682,624 (3.7%) of South African individuals (Statictics South Africa, 2018b).

While the statistics may reflect individuals directly affected by crime, law enforcement officials, medical professionals, and family and friends of those victims may also suffer from traumatisation (American Psychiatric Association, 2013), which suggests a much larger affected population. This translates into a considerable number of South African residents who may need counselling or therapy.

With only about 4,800 registered clinical and counselling psychologists (HPCSA, 2019) practicing in South Africa, psychologists represent a scarce resource. The July 2018 population estimate in South Africa was 57,725,600 (Statistics South Africa, 2018a), which implies 8.3 psychologists per 100,000 of the population. This is about a quarter of the

equivalent number of 33.9 per 100,000 in 2014 in the United States (American Psychological Association, 2014). Being limited in number, South African psychologists must supply mental health services to the South African population to the best of their ability.

Psychologists are exposed to the distress and traumatic material of their clients during therapy and working with survivors of crime puts them at risk of being traumatised (Salston & Figley, 2003). An essential aspect of the therapeutic relationship is empathy (Laverdière, Kealy, Ogrodniczuk, Chamberland, & Descôteaux, 2019). Empathy, however, leaves the therapist vulnerable to developing what Russell and Brickell (2015) refer to as compassion stress injury. This form of stress is often associated with the nature of trauma therapy, potentially leading to compassion fatigue and burnout among psychologists (Franza, Del Buono, & Pellegrino, 2015; Harker, Pidgeon, Klaassen, & King, 2016; Ludick & Figley, 2017).

1.3 Research Problem

Both the motivation to continue working as a psychologist and the ability to provide mental healthcare to the required ethical standards, may be linked to what Stamm (2010) describes as professional quality of life. This is considered to be a combination of the positive (compassion satisfaction) and negative aspects (compassion fatigue, burnout, and secondary traumatic stress) of being in a helping profession (Stamm, The concise ProQOL manual, 2010).

Self-care has been linked to higher levels of compassion satisfaction and reduced compassion fatigue and burnout (Alkema, Linton, & Davies, 2008; La Mott & Martin, 2019; Sharifian, 2019). Furthermore, psychologists' professional competence may be influenced by the self-care they practise over the course of their professional lives (Wise, Hersh, & Gibson, 2012).

While international literature yields some studies on the association between professional quality of life and self-care, no studies could be found that investigate this among South African psychologists. In addition, very few South African studies have been published on how prevalently positive and negative outcomes manifest in clinical and counselling psychologists who practice locally. Jordaan, Spangenberg, Watson, and Fouché (2007b) found above-average anxiety levels and mild depression suffered by more than half the South African clinical and counselling psychologists who participated in their study. In addition, moderate and high burnout levels occurred in about half of their study sample (Jordaan, Spangenberg, Watson, & Fouché, 2007a). From a phenomenological exploration, Sui and Padmanabhanunni (2016) reported increased stress arousal and reactivity in South African psychologists who frequently see clients traumatised by crime. This supports the finding of Laverdière et al. (2019) that Canadian psychotherapists who worked with trauma victims showed a positive association with secondary traumatic stress.

This dissertation addresses the lack of recent studies that assess the professional quality of life of South African clinical and counselling psychologists. Assessing the levels of compassion satisfaction, compassion fatigue, burnout, and self-care among South African psychologists from the early, mid and late career stages may provide insight into their level of functioning. Although self-care is an umbrella term, a focus on the self-care practices relevant to psychologists (Dorociak, Rupert, Bryant, & Zahniser, 2017a) may provide insight applicable to this occupation. Increased awareness of the relationships between the profession's risks and protective aspects could guide future training and support for this vital mental health resource.

1.4 Aim and Objectives

The aim of this study is to assess and compare levels of compassion satisfaction, compassion fatigue, burnout, and self-care among a sample of South African clinical and

counselling psychologists with varying years of experience; to investigate relationships among these variables and to augment these with qualitative data for a greater depth of understanding of the respective interrelations.

In order to attain the aim of the study, the following objectives were set:

- To assess levels of compassion satisfaction, compassion fatigue, burnout, and self-care in a sample of South African psychologists with varying years of experience;
- To explore relationships among levels of compassion satisfaction, compassion fatigue, burnout, self-care, trauma therapy sessions, and career stage;
- To investigate if psychologists from the early, mid and late career stages differ significantly with regard to levels of compassion satisfaction, compassion fatigue, burnout and self-care;
- To determine whether the number of trauma sessions, compassion satisfaction, burnout, and career stage are significant predictors of compassion fatigue;
- To explore the subjective experiences of practicing psychologists from different career stages regarding compassion satisfaction, compassion fatigue, burnout, and self-care.

In addition to the stated objectives, this study intends to offer suggestions, based on the synthesis of its results, relating to the training and support of psychologists at different stages of their careers.

1.5 Chapter Outline

Chapter 1 introduces the study by discussing the background, research problem, aim and objectives of the study.

Chapter 2 is a review of existing literature on the constructs explored in this study, with emphasis on the findings related to mental health professionals. It provides an overview of each construct, how they relate to career stage, and interrelationships among the constructs and biographic variables.

Chapter 3 describes the research design and method used in this study. The quantitative first phase and qualitative second phase are discussed with regard to sampling, measurement instruments, data collection, and data analysis. The chapter concludes with a summary of ethical considerations observed in the study.

Chapter 4 reports the quantitative results from the first phase, and Chapter 5 follows with the qualitative results from the second phase of the study.

Finally, Chapter 6 provides a detailed discussion of the results and highlights limitations in the interpretation of the study outcomes. It also outlines subsequent recommendations.

1.6 Conclusion

Chapter 1 emphasises the importance of the role of psychologists in South Africa, where crime contributes to a potentially large traumatised population. Providing therapy to clients traumatised by crime and other distressing experiences may subject psychologists to the development of compassion fatigue and burnout. Based on this, the present study aims to assess aspects of psychologists' professional functioning and self-care, to explore the relationships among these, and to formulate recommendations for training and support of South African psychologists.

Chapter 2 follows with a review of the literature relevant to this study.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter reports on the literature that explores the constructs pertinent to this study. These constructs include compassion satisfaction, compassion fatigue, burnout, and self-care of psychologists. In addition, findings related to the different career stages of psychologists are explored. Finally, the interrelationships among the constructs under investigation and the framework for the study are discussed.

Some of the literature discussed includes research about other helping professions that work with traumatised clients, as the results of those studies provided valuable insights that translate to the context and experiences of psychologists. While this study focuses on clinical and counselling psychologists, the terms psychologists, therapists, clinicians and practitioners are used interchangeably.

2.2 Professional Quality of Life of Psychologists

As briefly mentioned in 1.3, the professional quality of life of psychologists refers to their experience of being engaged in a helping profession, which includes the positive aspects they gain and negative aspects they suffer due to their work (Stamm, 2010). Compassion is defined as "the feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help" (Goetz, Keltner, & Simon-Thomas, 2010, p. 351). Psychologists' compassion likely attracted them to the profession, while their role in relieving their clients' suffering brings them satisfaction and contributes to their motivation to continue working in this field (Radey & Figley, 2007). Professional involvement with suffering clients may also lead to negative outcomes for therapists (Figley, 2002). The two sides of professional quality of life are aptly named compassion satisfaction and compassion fatigue (Stamm, 2002). The framework adopted by Stamm (2010) for professional quality of life is depicted in Figure 2.1.

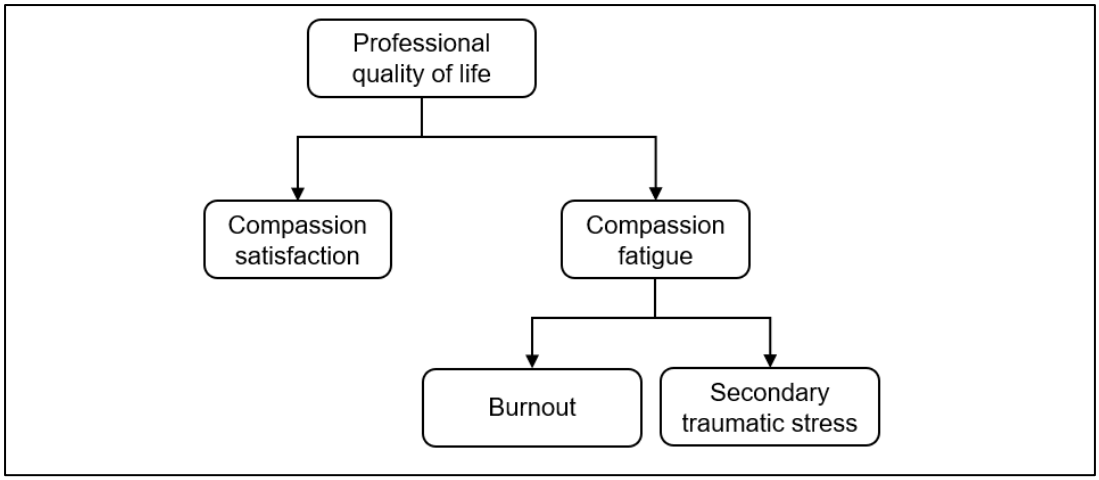

Figure 2. 1. Diagram of professional quality of life (Stamm, 2010).

From Figure 2.1 it can be seen that compassion fatigue is conceptualised as a combination of burnout and secondary traumatic stress (Stamm, 2010). Stamm (2010) also offered a theoretical path analysis containing the elements of professional quality of life of those helping the traumatised. The depiction of this theoretical path analysis in Figure 2.2 shows that compassion satisfaction and compassion fatigue are affected by the combination of the personal, work-related, and client-related environment.

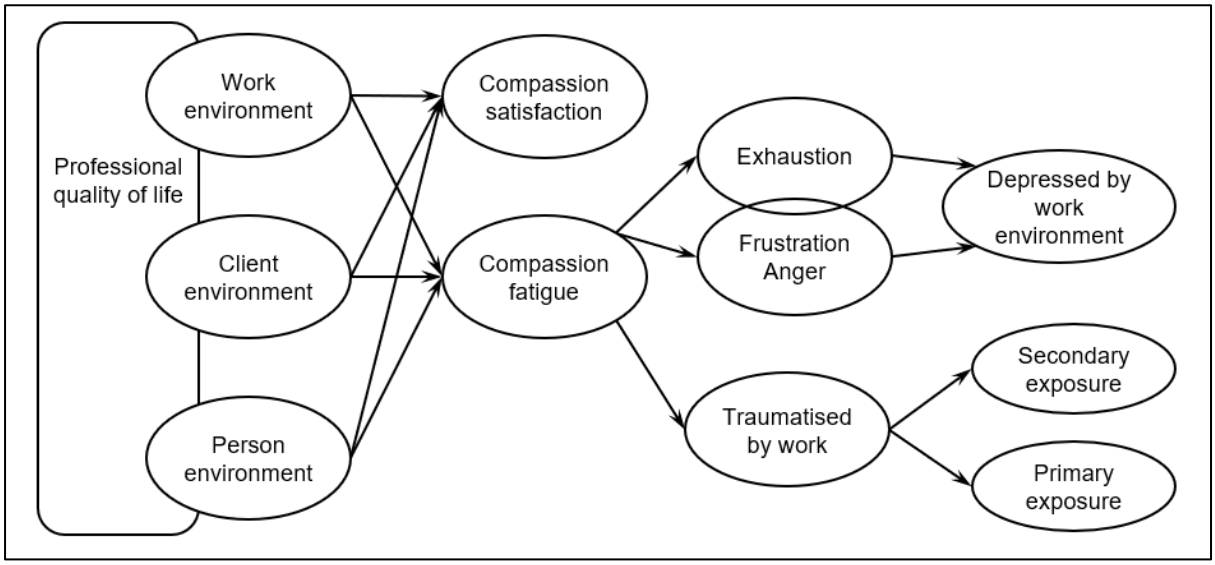

Figure 2. 2. Theoretical path analysis of professional quality of life (Stamm, 2010).

From Figure 2.2 it is worth noting that work-related trauma can be caused by both primary and secondary exposure. For psychologists, secondary exposure represents

secondary traumatic stress from exposure to clients' past traumatic experiences dealt with in therapy. Burnout is represented by the exhaustion, frustration, anger, and being depressed by the work environment depicted in Figure 2.2 (Stamm, 2010).

Although compassion satisfaction is a fairly unambiguous construct, the literature contains some debate on the constructs that represent the negative outcomes that helping professionals experience from being exposed to secondary trauma. These negative outcomes include vicarious traumatisation, secondary traumatic stress, and compassion fatigue. Burnout is a more general negative outcome not necessarily related to secondary trauma. All these constructs are subsequently discussed.

2.3 Compassion Satisfaction

2.3.1 Definition of compassion satisfaction.

Compassion satisfaction is defined as the enjoyment or contentment experienced by helping professionals from their ability to aid others by effectively doing their work (Craig & Sprang, 2010; Stamm, 2010). In her pursuit to explain many helpers' apparent resistance to negative outcomes despite their exposure to secondary trauma through their work, Stamm (2002) included the compassion satisfaction construct in her study of outcomes among helpers. The emotional reward of being a therapist, as well as the motivation to continue practicing as such, arguably lies in psychologists experiencing this positive aspect of professional quality of life. Affective aspects representing compassion satisfaction include perceived success in the process of providing help and positive feelings towards career choice and oneself (Stamm, 2010)

A related, though distinct concept is vicarious post-traumatic growth, which refers to the positive personal growth experienced by therapists through the involvement with and witnessing of clients overcoming their trauma (Arnold, Calhoun, Tedeschi, & Cann, 2005).

Killian, Hernandez-Wolfe, Engstrom, and Gangsei (2017) preferred the term vicarious resilience to describe a similar effect in therapists.

2.3.2 Compassion satisfaction research findings.

According to Radey and Figley (2007), the key to producing compassion satisfaction is achieving a high ratio of positivity to negativity. This outcome arguably depends on the ability of the clinician to discern and assess an appropriate level of altruistic engagement, in combination with increasing positive affect; intellectual, social, and physical resources; and self-care (Radey & Figley, 2007).

Wagaman, Geiger, Shockley, and Segal (2015) obtained data to demonstrate the significant effect of affective response − the automatic component of empathy that is driven by the mirror neuron system − on increasing compassion satisfaction. They also found that self-other awareness (a cognitive aspect of empathy that supports practitioners' ability to set boundaries between themselves and clients) may increase compassion satisfaction (Wagaman et al., 2015). A study by Laverdière et al. (2019) reported a strong positive association between dispositional empathy and compassion satisfaction in a study investigating the professional quality of life of Canadian psychotherapists (n = 240).

Linley and Joseph (2007) reported that a personal history of trauma was positively associated with increased personal growth. McKim and Smith-Adcock (2014) found higher levels of compassion satisfaction in trauma counsellors who had indicated more control in the work setting and had more years of experience. State mindfulness was another factor found to possibly moderate the detrimental effect of personal trauma history on compassion satisfaction (Martin-Cuellar, Atencio, Kelly, & Lardier Jr, 2018).

Killian (2008) reported a positive association between compassion satisfaction and both social support and a perception of adequate autonomy at work. He also found a negative relationship between more therapy hours and compassion satisfaction (Killian, 2008). These

findings, as well as those discussed in the previous paragraphs, support Stamm's (2010) assertion that compassion satisfaction is influenced by the person environment, work environment, and client environment (see Figure 2.2).

Finding that specialised training in trauma may increase compassion satisfaction, Sprang et al. (2007) asserted that this might be because the skills acquired in assessing and treating trauma clients lead to better treatment outcomes. This draws attention to the importance of South African psychologists acquiring trauma training, which ultimately also benefits their trauma clients.

The compassion fatigue resilience (CFR) model of Ludick and Figley (2017), discussed in 2.8, offers compassion satisfaction as one of the protective factors in the development of compassion fatigue. Thompson, Amatea, and Thompson (2014) also reported compassion satisfaction to be a resource that counsellors can utilise to handle perceived stress.

There is some debate about the constructs that represent the negative outcomes helping professionals experience from being exposed to secondary trauma − these terms are subsequently discussed.

2.4 Compassion Fatigue and Related Constructs

Different terms have been used to describe the adverse effects that follow exposure to the details of primary trauma experienced by others. These terms include vicarious traumatisation (McCann & Pearlman, 1990), secondary traumatic stress (Figley, 1995), and compassion fatigue (Figley, 2002).

2.4.1 Definition of vicarious traumatisation.

McCann and Pearlman (1990) coined the term vicarious traumatisation to describe the cumulative process resulting in negative changes in therapists who are involved with

traumatised clients. Over time, being confronted with the details of traumatic experiences and their impact on clients may cause therapists to experience changes in their affect and perceptions of the world; including aspects such as safety concerns for themselves and those close to them, trust, and spirituality (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995). These changes may include a negative shift in cognitive schemas of the world, themselves, and the nature of people and may persist long after exposure during therapeutic contact (McCann & Pearlman, 1990). In addition, a previously neutral object may become a cue that triggers an image of a client's traumatic experience (McCann & Pearlman, 1990). This effect could be called vicarious classical conditioning (Bandura & Rosenthal, 1966), as the process does not happen from the therapist's own experience, but through attentively listening to and imagining a client's experience. Personal trauma exposure is also a factor that possibly contributes to the development of vicarious traumatisation (Pearlman & Mac Ian, 1995).

2.4.2 Definition of secondary traumatic stress.

In contrast to the cumulative way vicarious traumatisation develops, secondary traumatic stress is an acute stress response caused by exposure to a traumatised person whose suffering the affected person wants to alleviate (Figley, 2002; Stamm, 2010). In other words, secondary traumatic stress is generated due to being compassionate and empathic towards the suffering person (Figley & Figley, 2017), which is why psychologists are potentially vulnerable to secondary traumatic stress in the therapeutic context. Secondary traumatic stress is experienced not only by helping professionals, but also by the friends and family of survivors (Figley, 1995).

2.4.3 Definition of compassion fatigue.

Figley (2002, p. 1435) defined compassion fatigue is "a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders [and] persistent arousal (e.g. anxiety) associated with the patient." Compassion fatigue is associated with feeling helpless, confused, and isolated from support (Figley, 2002). Figley (2002) has used the term secondary traumatic stress disorder as synonymous with compassion fatigue. Although the DSM-5 (American Psychiatric Association, 2013) diagnostic criteria for posttraumatic stress disorder (PTSD) provides for the development of this disorder from indirect exposure to severe trauma, the criteria do not yet fully capture the type of exposure from therapeutic interaction that may lead to compassion fatigue in psychologists.

Psychologists are exposed to not only details of the traumatic experiences of clients but also the trauma symptoms of their clients. This exposure can generate secondary traumatic stress, which, with recurring exposure, can accumulate to lead to compassion fatigue (Figley, 2002; Figley & Ludick, 2017). When practitioners suffer from compassion fatigue, their capacity for client interaction and their interest in others' suffering are diminished (Figley, 2002).

Franza et al. (2015) equated compassion fatigue to secondary traumatic stress, distinguishing these constructs from burnout as resulting specifically from contact with the trauma and suffering of clients. As not even a gathering of experts involved in the field of compassion fatigue, secondary traumatic stress, and vicarious traumatisation failed to agree on a term and scope to represent the negative impact of working with traumatised clients these definition are still up for the debate (Walsh, Mathieu, & Hendricks, 2017). An inclusive term, empathy-based stress, has been proposed by Rauvola, Vega, and Lavigne (2019). For the purpose of this study, the term compassion fatigue is used, as it seems to more closely

represent the detrimental effect of therapeutic trauma work presently under investigation. Due to the apparent lack of distinction between compassion fatigue and secondary traumatic stress in the literature, findings regarding both compassion fatigue and secondary traumatic stress are subsequently discussed.

2.4.4 Compassion fatigue research findings.

The etiological model for compassion fatigue proposed by Figley (2002) suggests that the empathic response of psychotherapists following exposure to clients may generate compassion stress − the demand to relieve clients' suffering. Compassion stress can be prevented or reduced if therapists appropriately disengage from clients' suffering between therapy sessions and rationally recognise the boundaries of their responsibility to relieve the suffering. However, the combination of escalating compassion stress, prolonged periods of shouldering therapeutic responsibilities without breaks, and clients triggering therapists' traumatic memories related to previous experiences can contribute to the development of compassion fatigue. Any additional personal or professional life disruption added to these stressors would increase the likelihood of developing compassion fatigue (Figley, 2002).

Several previous studies have reported a positive association between secondary traumatic stress and working with victims of trauma (Baird & Kracen, 2006; Laverdière et al., 2019). From their literature synthesis, Baird and Krachen (2006) concluded that the extent of exposure to traumatic material was a persuasive predictor of secondary traumatic stress. Laverdière et al. (2019) investigated the professional quality of life among 240 psychologists and found that those therapists who worked with trauma clients reported higher secondary traumatic stress.

In a qualitative study, six South African psychologists with extensive professional exposure to survivors of trauma reported experiencing a combination of symptoms that included nightmares or intrusive thoughts; persistent negative emotions (e.g. sadness, anger,

and helplessness); alterations in arousal and reactivity (e.g. irritability, insomnia, and hyper-vigilance); somatic symptoms (e.g. headaches and muscle tension); and disrupted cognitive schemas (Sui & Padmanabhanunni, 2016). As these symptoms are discernible features of compassion fatigue and vicarious traumatisation, they illustrate the impact on psychologists who work with survivors of trauma.

McKim and Smith-Adcock (2014) found a positive relationship between compassion fatigue and the amount of exposure to secondary trauma − the latter being a combination of the intensity of client trauma symptoms and the number of trauma clients in the total caseload. Diehm, Mankowitz, and King (2018) also found the extent of secondary trauma exposure to be related to secondary traumatic stress. This is similar to previous research that found the proportion of clients with PTSD predicted compassion fatigue in therapists (Craig & Sprang, 2010). Killian's (2008) trauma specialist participants emphasised high caseload – indicating high exposure to trauma clients – as one of the main risk factors related to compassion fatigue. Complex patient cases and high caseloads also featured as a contributing factor to compassion fatigue in a qualitative study among Swedish psychologists (Norrman Harling, Högman, & Schad, 2020)

Beaumont, Durkin, Hollins Martin, and Carson (2016) discovered an inverse relationship between self-compassion and compassion fatigue among trainee psychotherapists and counsellors. In a systematic review, Singh, Karanika-Murray, Baguley, and Hudson (2020) found that job demands positively relate to compassion fatigue. These job demands included primary and secondary workplace trauma, workload not conforming to expectations, and working in an inpatient setting. In contrast, factors that reduce compassion fatigue included organisational resources, such as employee assistance services and sufficient guidance on working with traumatised clients, and support from co-workers and supervisors (Singh et al., 2020).

Although a number of previous studies reported a positive relationship between psychologists' past personal trauma experiences and compassion fatigue or secondary traumatic stress (Diehm et al., 2018; Killian, 2008; Pearlman & Mac Ian, 1995; Rossi et al., 2012), others did not find such a correlation (McKim & Smith-Adcock, 2014; Reichert Schimpff, 2019). It is worth considering that the influence of past personal trauma could be moderated by both the protective factors that affect the risk for developing compassion fatigue (Turgoose & Maddox, 2017) and by the therapist having resolved the effects of that trauma (Salston & Figley, 2003). A recent study by Reichert Schimpff (2019) found that a previously traumatised therapist's own posttraumatic growth mediated the association between PTSD and compassion satisfaction, while compassion satisfaction, in turn, mediated the association between PTSD and compassion fatigue.

In a study with South African trauma workers (n = 64), MacRitchie and Leibowitz (2010) found significantly higher secondary traumatic stress scores in those who had been exposed to direct criminal violence, while secondary exposure measured via caseload was not related to secondary traumatic stress. They also reported a moderate negative association between social support and secondary traumatic stress and a moderate positive association between trauma workers' empathy levels and secondary traumatic stress. However, for trauma workers who had experienced primary violent crime-related trauma, social support did not show a moderating effect in the development of secondary traumatic stress. Workers who presented with higher secondary traumatic stress had higher levels of empathy (MacRitchie & Leibowitz, 2010). Thomas (2013) found only personal distress, an aversive component of empathy that focuses on reducing one's own distress rather than eliciting prosocial caring, to be related to increased compassion fatigue and burnout and decreased compassion satisfaction.

A study by Wagaman et al. (2015) observed that the ability to regulate one's emotional reaction to client interaction safeguards against secondary traumatic stress from the recurrent exposure to secondary trauma and client suffering. A further finding of Wagaman et al.'s (2015) research was that self-other awareness is a possible factor that prevents secondary traumatic stress. This provides support for the finding that disengagement, as in Figley's (2002) etiological model of compassion fatigue, can prevent or reduce compassion stress. Disengagement refers to a conscious release of the distress of clients outside of therapy sessions (Figley, 2002). Similarly, McKim and Smith-Adcock (2014) found that over-involvement with clients was related to higher compassion fatigue. They argued that poorly defined practitioner-client boundaries caused the practitioner to experience more of a traumatised client's distress, which resulted in higher compassion fatigue (McKim & Smith-Adcock, 2014).

Even though several studies found that the female gender was at higher risk for compassion fatigue (Ivicic & Motta, 2017; Rossi et al., 2012; Sprang, Clark, & Whitt-Woosley, 2007; Thompson et al., 2014; Zeidner & Hadar, 2014), other studies did not (Craig & Sprang, 2010; Sprang, Craig, & Clark, 2011).

2.5 Burnout

2.5.1 Definition of burnout.

Burnout can be considered as "a state of physical, emotional and mental exhaustion that results from long-term involvement in work situations that are emotionally demanding" (Schaufeli & Greenglass, 2001, p. 501). According to Kristensen, Borritz, Villadsen, and Christensen (2005) the essence of burnout is fatigue and exhaustion attributed to specific areas of life. Burnout is therefore defined as a state of domain-specific physical and psychological fatigue and exhaustion, categorised as personal, work-related, or client-related burnout (Kristensen et al., 2005). This is a deviation from the earlier conceptualisation of

burnout by Maslach and Jackson (1981) who equated it to dimensions of emotional exhaustion, depersonalisation or detachment, and a perception of diminished personal accomplishment. Kristensen et al. (2005) criticised Maslach and Jackson's (1981) burnout model as measuring three independent levels of burnout per individual and disputed the appropriateness of the personal accomplishment dimension as part of burnout. While Stamm (2010) categorised burnout as a component of compassion fatigue, Newell and MacNeil (2010) pointed out that burnout is not specific to trauma work. The construct is also not limited to helping professions, as is evident from the later adaptations to the Maslach Burnout Inventory to facilitate measuring burnout in more generic populations (Maslach & Leiter, 2016). Nevertheless, the experience of burnout is an important reality among helping professionals.

In contrast to secondary traumatic stress (see 2.4.2), burnout develops gradually due to a combination of occupational stressors related to the individual, clients dealt with, and the organisational setting (Maslach & Jackson, 1981; Maslach, Schaufeli, & Leiter, 2001). These stressor areas correspond with the domains of personal, client-related, and work-related burnout as proposed by Kristensen et al. (2005).

2.5.2 Burnout research findings.

Several researchers reported fairly strong positive correlations between burnout and compassion fatigue (Rossi et al., 2012; Thompson et al., 2014; Zeidner, Hadar, Matthews, & Roberts, 2013).

It is clear from the literature that type of client, work load, and work setting factors can affect burnout. Craig and Sprang (2010) found the following to be related to burnout: a caseload with a higher proportion of PTSD clients and therapists not employing evidence-based methods and lacking specialist training in treating trauma. Psychologists with higher caseloads and those whose work context was exclusively institutional reported higher levels

of burnout (Laverdière et al., 2019). In a South African study, more weekly client hours and issues with medical aid payments were also positively associated with burnout (Jordaan et al., 2007a). A systematic review by O'Connor, Neff, and Pitman (2018) reported a consistent positive correlation between burnout and a heavy workload.

Several other variables have been explored in relation to burnout. Di Benedetto and Swadling (2014) reported a strong negative association between burnout and mindfulness. Thompson et al. (2014) reported an inverse relationship between burnout and both compassion satisfaction and mindfulness, while negatively perceived working conditions strongly predicted burnout. Another characteristic of therapists, dispositional empathy, showed a negative association with burnout (Laverdière et al., 2019). Perfectionism was found to influence stress, which, in turn, was positively related to burnout in clinical psychologists (D'Souza, Egan, & Rees, 2011). In contrast, high scores on self-compassion were correlated with less burnout in a study of students in counsellor and psychotherapist training programmes (Beaumont et al., 2016).

Previous studies have found higher burnout among younger and less experienced psychologists (Craig & Sprang, 2010; Di Benedetto & Swadling, 2014; Simionato & Simpson, 2018) and psychologists who are overinvolved in their clients' problems (Simionato & Simpson, 2018). In a study comparing the burnout scores of Australian clinical psychologists, being of a younger age was significantly related to higher burnout scores, with 8% of participants' scores high enough to be considered at risk for burnout (D'Souza et al., 2011). The level of burnout measured in South African psychologists was higher in 2007 than in previous studies respectively conducted about one and two decades earlier (Jordaan et al., 2007a). While this is not a longitudinal finding, it evokes a level of concern about burnout in South African psychologists that warrants further exploration.

This section, which examines literature around burnout, concludes the individual discussions of constructs related to the professional quality of life of psychologists. The following section explores self-care as it relates to the psychology profession.

2.6 Self-Care

2.6.1 Definition of self-care.

Self-care is "a multidimensional, multifaceted process of purposeful engagement in strategies that promote healthy functioning and enhance well-being" (Dorociak et al., 2017a, p. 326). Although this definition was used for the purposes of the current study, further interesting perspectives emerged from a qualitative study with New Zealand counsellors (Lin & Wilson, 2019). They reported that self-care includes both common and unique elements, both activities and mindset, and that self-care changed over time as practitioners learn and grow (Lin & Wilson, 2019).

The application of self-care practices is an ethical responsibility for psychologists to maintain professional competence (Barnett, Baker, Elman, & Schoener, 2007; Figley, 2002; Wise et al., 2012). According to Dattilio (2015), psychologists should recognise that they are subject to stress and distress from their work and take measures to reduce and cope with these effects. In contrast to the reactive practise of self-care to counteract impairment, Maranzan et al. (2018) argued for self-care to be approached as a proactive competency in the training and practice phases of the psychology profession. Presenting a similar point of view, Wise et al. (2012) considered effective self-care to be part of the daily routine of psychologists. Psychologists should realise that a lack of self-care affects not only themselves but also their clients, loved ones, and the profession (Barnett et al., 2007). This implies an even broader ethical responsibility than just the therapeutic context.

2.6.2 Self-care research findings.

Five factors have been found to be pertinent to the self-care of psychologists: professional support, professional development, life balance, cognitive awareness, and daily balance (Dorociak et al., 2017a). Rupert and Dorociak (2019) found that self-care in these areas may lower perceived stress, which, in turn, predicts enhanced life satisfaction and reduced burnout among psychologists. Further analyses also indicated the particular value of specifically life balance, cognitive awareness, and daily balance in the reported well-being of psychologists (Rupert & Dorociak, 2019).

Frequent engagement with colleagues, which includes aspects such as peer support, supervision, and personal therapy, could constitute an important part of self-care for psychologists (Barnett et al., 2007; Linley & Joseph, 2007). Jordaan et al. (2007b) also encouraged support groups among colleagues and young psychologists pursuing supervision from more experienced colleagues. Lack of time and difficulty in obtaining an acceptable therapist have been reported as the most prominent barriers to psychologists engaging in personal psychotherapy as a form of self-care (Bearse, McMinn, Seegobin, & Free, 2013).

From the qualitative data in a study with South African psychologists, self-care was identified as one of the themes related to the well-being of psychologists (Hitge & Van Schalkwyk, 2018). Ludick and Figley (2017) also highlighted self-care as one of the factors that should be cultivated to promote resilience against compassion fatigue.

Given the importance of self-care, very limited empirical research related to the helping professionals is available (Dorociak et al., 2017a). From the literature both proactive and reactive self-care seem to be essential for the professional competence and overall well-being of psychologists. This implies the importance of emphasising and implementing self-care practices from the training period throughout the time of practising as a psychologist.

The next section summarises findings about self-care and the previously discussed constructs as they relate to the career stages.

2.7 Career Stages

Dettle (2014) and Dorociak, Rupert, and Zahniser (2017b) defined the early career period as the first seven years of practice, the mid-career period as eight to 20 years, and the late career period as more than 20 years of being in practice. This delineation applies to the present study.

Dorociak et al. (2017b) pointed out that each career stage correlates to specific challenges in terms of family context and career. The early career period might involve stressors such as establishing a job position, paying student loans, and starting a family. The mid career period might hold more job responsibilities and family obligations, while the late career period likely includes decisions regarding aspects such as retirement (Dorociak et al., 2017b).

Previous studies have found more years in practice to be associated with higher compassion satisfaction (Craig & Sprang, 2010; Laverdière et al., 2019; McKim & Smith-Adcock, 2014; Wagaman et al., 2015). Laverdière et al. (2019) explained this association as either resulting from therapists' feeling of satisfaction increasing over time or persistence in the field by those who enjoy more fulfilment from their work.

Thompson et al. (2014) reported a negative association between years of experience and compassion fatigue among mental health counsellors. Similarly, less clinical experience predicted higher levels of compassion fatigue among mental health providers (Sprang, Clark, & Whitt-Woosley, 2007).

In a study with early career mental health professionals, Volpe et al. (2014) found burnout to be present and argued for programmes of burnout recognition and prevention to be included in training. Craig and Sprang (2010) reported that younger age significantly

predicted burnout in trauma treatment therapists. Jordaan et al. (2007a) also found younger age to be associated with higher levels of burnout in South African psychologists. Several studies associated more years in practice with lower burnout (Craig & Sprang, 2010; Dorociak et al., 2017b; Thompson et al., 2014; Wagaman et al., 2015). Although Lasalvia et al. (2009) reported higher burnout among those who had worked longer in mental health, this applied to the mental health staff of community-based centres, which implies that the work setting may influence this outcome. Linley and Joseph (2007), however, also found more years of doing therapeutic work to predict higher burnout among participants working mostly in individual practices or combined settings. Therefore, while early career psychologists seem to be more vulnerable to burnout, it must be considered that other variables may influence this relationship.

In early career psychologists, emotional exhaustion and insufficient attention to self-care were the most concerning aspects (Dorociak et al., 2017b). Late career psychologists' mean scores on the frequency of self-care and coping self-efficacy were significantly higher and perceived stress scores significantly lower than those of early career psychologists (Dettle, 2014). Dorociak et al. (2017b) found evidence of greater professional well-being, less perceived stress, and more frequent application of self-care in late career psychologists, as compared to the mid and early career groups. Interpreting these findings in combination with those of Laverdière et al. (2019), it may either be that self-care plays a protective role in terms of the negative effects of practising as a psychologist or that late career psychologists are those who have persisted in the field due – in part – to the application of frequent self-care.

2.8 Interrelationships of variables

Several researchers have concluded that burnout is inversely related to compassion satisfaction (e.g. Cummings, Singer, Hisaka, & Benuto, 2018; Kraus, 2005). Cummings et al.

(2018) concluded that compassion satisfaction may reduce secondary traumatic stress and vicarious traumatisation by lowering burnout. Interestingly, Dar and Iqbal (2020) reported a curvilinear relationship between secondary traumatic stress and vicarious post-traumatic growth, with moderate levels of secondary traumatic stress resulting in the highest vicarious post-traumatic growth.

In a study of victim advocates − a professional group with high exposure to client trauma − Cummings et al. (2018) found high correlations between burnout, vicarious traumatisation and secondary traumatic stress. They considered this indicative of the high likelihood that individuals suffering one of these distressed states would also suffer from another. Stamm (2010), however, suggested that it is possible to experience low burnout while suffering from high secondary traumatic stress following exposure to details of the first-hand traumatic experiences of clients. Considering that compassion fatigue is defined as an outcome resulting from secondary traumatic stress (Figley & Ludick, 2017) (see 2.4.3), this suggestion may be true in the short term.

Rossi et al.'s (2012) findings confirmed that psychological distress relates significantly to higher compassion fatigue and burnout. Moreover, their results showed that compassion fatigue and burnout are positively correlated (Rossi et al., 2012). This finding supports other studies reporting burnout to be positively associated with compassion fatigue (Kraus, 2005; Ray, Wong, White, & Heaslip, 2013; Singh et al., 2020). While these correlations have been identified between burnout and compassion fatigue, no causal direction has been indicated. From two longitudinal studies reported by Shoji et al. (2015), burnout was found to predict secondary traumatic stress, while the reverse was not true. In a qualitative study, Swedish clinical psychologists indicated that the time required for work logistics contributed to compassion fatigue (Norrman Harling et al., 2020). They mentioned that this time might have been better used for reflection and recovery from the effects of

therapeutic contact (Norrman Harling et al., 2020). It can be argued that the logistical load may contribute to work-related burnout, which may be a factor in the association found between compassion fatigue and burnout.

Various studies have researched the relationships between self-care and other factors. Several researchers have reported a positive relationship between self-care and compassion satisfaction (Kraus, 2005; La Mott and Martin, 2019; Sharifian, 2019). Some of these studies also confirmed an inverse relationship between self-care and burnout among trauma therapists as well as clinical and counselling psychology trainees (La Mott and Martin, 2019; Sharifian, 2019). An increase in self-care was related to lower burnout, lower secondary traumatic stress, and higher compassion satisfaction in Catlin-Rakoski's (2012) study with mental health therapists. The results of a study focused on child welfare workers included positive associations between self-care and compassion satisfaction, an inverse relationship between self-care and burnout, and no relationship between self-care and secondary traumatic stress (Salloum, Kondrat, Johnco, & Olson, 2015). Manning-Jones, De Terte, and Stephens (2016) found an inverse relationship between self-care and secondary traumatic stress. Kraus (2005) found no significant relationship between self-care and compassion fatigue among mental health professionals working with adolescent sex offenders. It therefore seems that the positive relationship between self-care and compassion satisfaction is consistently validated, while the relationship between self-care and both burnout and compassion fatigue (or secondary traumatic stress) is less predictable.

Combining 12 factors, the CFR model developed by Ludick and Figley (2017) offers an explanation of factors that impact the development of secondary traumatic stress and moderating factors that contribute towards resilience against compassion fatigue. Figure 2.3 depicts the CFR model graphically.

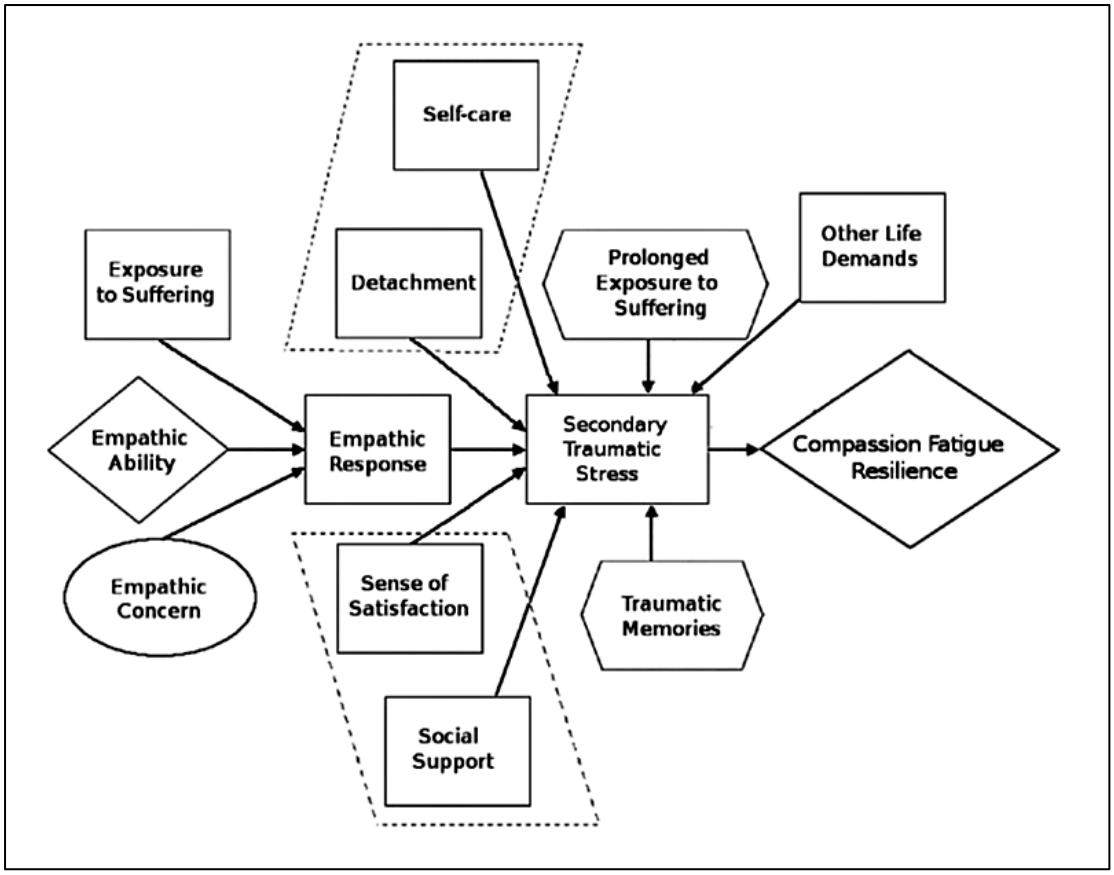

Figure 2. 3. Compassion fatigue resilience model (Ludick & Figley, 2017).

According to Ludick and Figley's (2017) CFR model, exposure to suffering, the ability to empathically recognise the suffering, and the empathic concern aimed at reducing the distress of clients combine to produce an empathic response in the practitioner, the intensity of which varies according to the three antecedents mentioned. The factors that combine with empathic response to exacerbate secondary traumatic stress are persistent long-term exposure to suffering, reactivation of traumatic memories from primary or secondary exposure, and demanding life stressors (Ludick & Figley, 2017). The factors in the CFR model that moderate the development of secondary traumatic stress towards compassion fatigue resilience are self-care, the ability to detach from the suffering of clients outside of work, a sense of satisfaction, and the social support of caring people (Ludick & Figley, 2017). Diehm et al. (2018) also found evidence that social support can moderate the effect of exposure time to traumatised clients and secondary traumatic stress.

While the CFR model (Ludick & Figley, 2017) offers interesting options for investigation, the present study used Stamm's (2010) model of professional quality of life. In addition, this study investigated the role of self-care as it relates to the positive and negative outcomes of practising as a psychologist. The framework for the constructs and relationships investigated in this study is diagrammatically depicted in Figure 2.4.

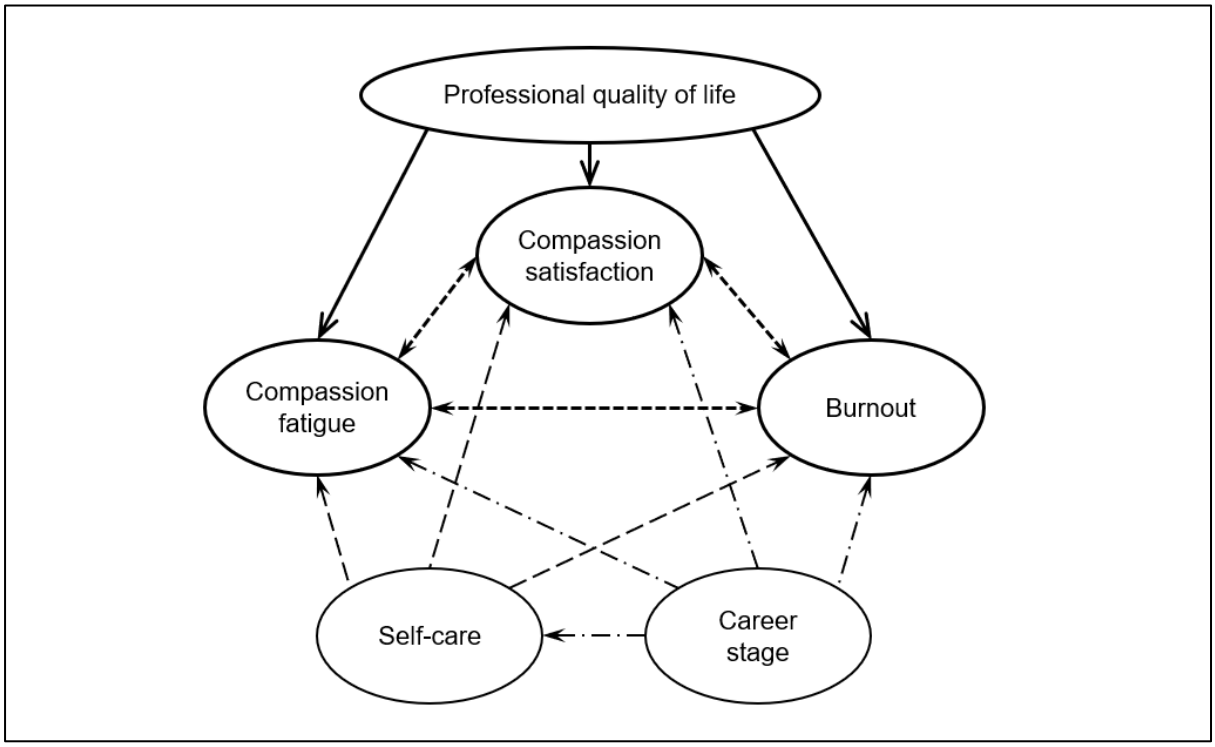

Figure 2. 4. Framework for the current study.

2.9 Conclusion

This chapter highlights the findings from previous research pertaining to the constructs that form the focus of the current study. These constructs include compassion satisfaction, compassion fatigue, burnout, and self-care. Certain relationships found among constructs are fairly consistent, while other associations were unconvincing. South African studies that investigate these constructs are limited. This study aims to make a useful contribution to the healthy professional functioning of local clinical and counselling psychologists.

The next chapter describes the research design and method.

CHAPTER 3: RESEARCH DESIGN AND METHOD

3.1 Introduction

Chapter 3 describes the research design used in this study and the different steps employed in the research process. The initial section details the theoretical point of departure from which the project was approached. Then follows a discussion on the research design, sampling, and measurement instruments. The latter part of the chapter describes the data collection procedures, the data analyses conducted, and ethical considerations.

3.2 Research Design

Choosing a mixed method design provides the advantage of combining objective and subjective sources of data, allowing a fuller and more detailed understanding of the data collected and analysed (Christensen, Johnson, & Turner, 2015). The research design utilised in this study is a sequential mixed methods explanatory design (Ivankova, Creswell, & Stick, 2006) of a cross-sectional nature, the latter aspect implying data collection over a brief period of time (Christensen et al., 2015). The sequential mixed methods design involves the collection and analysis of quantitative and qualitative data in two separate phases, with one phase following the other (Christensen et al., 2015). In this study, the quantitative phase was conducted first, followed by the qualitative phase a few weeks later. The explanatory approach of this study was realised through an emphasis on the quantitative phase, while the subsequent qualitative phase served to augment the quantitative data (Leedy & Ormrod, 2014). This design is represented by the notation QUAN → qual (Christensen et al., 2015), with the results of the quantitative data guiding the selection of participants in the qualitative phase (Creswell & Zhang, The application of mixed methods designs to trauma research, 2009).

3.3 Sampling

3.3.1 Quantitative sampling.

The population of interest in this study was clinical and counselling psychologists who are practising psychotherapy in South Africa. This approach aimed to obtain data from psychologists who, to a reasonable extent, share a similar professional therapeutic context.

The sample for the quantitative first phase was selected using simple random sampling, a method implying that all individuals in a population have an equal chance of being selected (Gravetter & Forzano, 2016). Simple random sampling was used in an attempt to select a relatively representative sample from the population.

The inclusion criteria were:

- current registration with the Health Professions Council of South Africa (HPCSA) in the categories clinical or counselling psychology;
- practising psychotherapy in South Africa;
- having practised as a registered psychologist for at least six months; and
- an email address that is available online.

The sampling was therefore done randomly within the constraints of readily available contact details. In addition, staff members at academic institutions were excluded to avoid possibly confounding the data with non-therapy work contexts.

The sampling frame for this study was compiled through the selection of clinical and counselling psychologists registered with the HPCSA Professional Board for Psychology. After applying the inclusion criteria, three career stages were distinguished by utilising registration dates to indicate maximum length of practice. Psychologists were divided into the career groups based on years of practice: early career (up to seven years), mid career (more than seven and up to 20 years), and late career (more than 20 years). A random sample of

1,200 names was generated, divided equally per career stage. Psychologists who could not be reached were replaced by randomly selected names from their career groups.

The researcher recruited participants via email with the information letter as attachment (see Appendix A). Of the 1,200 psychologists invited to participate in this study, the finalised sample consisted of 238 participants. Data from the online questionnaire were sorted into career groups according to the number of years of practice indicated in the responses. Table 3.1 provides a summary of the sample demographics.

Table 3. 1
Summary of quantitative sample demographics

Characteristic	Early career group		Mid career group		Late career group		Complete sample	
	n	%	*n*	%	*n*	%	*n*	%
Number of participants	85	35.7	76	31.9	77	32.4	238	100
Gender								
Male	15	17.6	8	10.5	21	27.3	44	18.5
Female	70	82.4	68	89.5	56	72.7	194	81.5
Type of registration								
Clinical	58	68.2	51	67.1	52	67.5	161	67.6
Counselling	27	31.8	25	32.9	25	32.5	77	32.4
Age								
< 30 years	15	17.6	-		-		15	6.3
30-39 years	51	60.0	18	23.7	-		69	29.0
40-49 years	19	22.4	31	40.8	9	11.7	59	24.8
50-59 years	-		19	25.0	35	45.5	54	22.7
60-69 years	-		8	10.5	28	36.4	36	15.1
≥ 70 years	-		-		5	6.5	5	2.1
Primary work environment								
Solitary private practice	36	42.4	49	64.5	62	80.5	147	61.8
Shared private practice	31	36.5	14	18.4	10	13.0	55	23.1
Public health	5	5.9	6	7.9	1	1.3	12	5.0
Other	13	15.3	7	9.2	4	5.2	24	10.1
Number of years in practice								
Range	1-7 years		8-20 years		21-42 years		1-42 years	
M (*SD*)	4.48 (1.65)		14.55 (4.00)		27.42 (5.16)		15.12 (10.22)	

3.3.2 Qualitative sampling.

Creswell and Plano Clark (2018) recommend selecting a small subsample from the quantitative first phase that can provide enough qualitative data to produce themes to explain the quantitative data of an explanatory sequential design. A few participants from the quantitative phase were therefore selected for the qualitative phase via purposeful sampling (Christensen et al., 2015), an approach meant to involve participants from the quantitative phase who could provide additional insight into the quantitative data. The parameters for the selection of qualitative participants were determined through perusal of the quantitative data. The researcher opted for purposeful extreme case sampling (Christensen et al., 2015) based on burnout scores, as quantitative participants who conducted a substantial number of weekly therapy sessions reported from high to low levels of burnout. The following inclusion criteria were set:

- participation in the online questionnaire of the first phase of this study;
- doing an average of 20 or more weekly therapy sessions;
- displaying either high burnout scores for at least two of the burnout subscales, or low burnout scores on all three subscales;
- willingness to participate in an online interview according to the informed consent form of the second phase of this study; and
- the ability to participate in an online interview via Zoom.

The researcher opted to include one participant with high burnout scores and one participant with low burnout scores from each of the career groups. This was aimed at elucidating the contrast in experiences from the subjective accounts of participants from each of the career stages.

The participants were invited via email to take part in this phase. Invitees who declined further participation were substituted as necessary. The recruitment email contained

a short description of the purpose of this phase and an invitation to participate in an online, semi-structured interview. A document containing the information letter and informed consent form for this phase was attached to the invitation (see Appendix B).

The final sample for the qualitative phase included six participants from the quantitative phase. Their pseudonyms were selected to reflect gender, the first letter (*e*, *m* or *l*) of their career group, and as a last letter either *l* for low burnout or *h* for high burnout. Thus, Edith is a pseudonym selected for a female from the early career group who indicated high levels of burnout, whilst Lionel indicates a male from the late career group who indicated low levels of burnout. Table 3.2 presents the interview participants and their biographical particulars.

Table 3. 2
Qualitative sample with biographical details

Name[a]	Career stage	Registration category	Age (years)	Gender	Years in practice	Primary work environment #	Sessions per week
Edith	Early	Counselling	35	Female	7	Shared PP	24
Estell	Early	Clinical	35	Female	5	Public health	28
Mitch	Mid	Clinical	46	Male	10	Public health	28
Michael	Mid	Clinical	58	Male	20	Solitary PP	45
Lilith	Late	Counselling	60	Female	30	Solitary PP	50
Lionel	Late	Counselling	65	Male	27	Solitary PP	50

Note. PP = Private practice.
[a]Assigned pseudonym.

3.4 Measurement Instruments

3.4.1 Quantitative measurements.

3.4.1.1 Biographical questionnaire.

A short biographical questionnaire was used to collect information about each participant's professional background. Table 3.3 lists the biographical details requested in the questionnaire.

Table 3. 3
Biographical details collected

Description
Type of registration
Number of years practising as a registered psychologist
Primary work environment
Age
Gender
Average number of therapy sessions per week in the preceding six months
Age group(s) of clients
Fraction of therapy sessions with trauma clients

The number of trauma therapy sessions per week was calculated by multiplying the number of therapy sessions per week by the fraction of trauma therapy sessions.

3.4.1.2 ProQOL-21.

Compassion satisfaction and compassion fatigue were assessed using the ProQOL-21, a revised version of the Professional Quality of Life Measure (ProQOL-5) (Stamm, 2009) as adapted by Heritage, Rees, and Hegney (2018). As per its copyright agreement, the complete original ProQOL-5 was included in the online questionnaire (Stamm, 2009). According to the permissions, the word *helper* was replaced with the word *therapist* in the statements to reflect the population of this study.

Use of the ProQOL-21 version was motivated by various independent evaluations of the ProQOL-5 psychometric properties. These highlighted psychometric issues with the subscales measuring burnout and secondary traumatic stress (Hemsworth, Baregheh, Aoun, & Kazanjian, 2018; Heritage et al., 2018; Sutjiono, Mar'at, & Risnawaty, 2019). Heritage et al. (2018) proposed the ProQOL-21 as an alternative scoring to the original ProQOL-5 that eliminates the weaknesses discovered in their analyses. Their version adjusted the weighting of the compassion satisfaction subscale items and combined a number of the burnout and

secondary traumatic stress items to produce a robust compassion fatigue subscale with confirmed construct validity (Heritage et al., 2018).

The ProQOL-21 consists of two subscales that measure compassion satisfaction and compassion fatigue, with 21 statements in total: 11 statements linked to compassion fatigue and 10 statements linked to compassion satisfaction. None of these items are reverse scored. Sample statements include "I believe I can make a difference through my work." (compassion satisfaction subscale) and "I feel trapped by my job as a therapist." (compassion fatigue subscale).

Each statement is rated on a 5-point Likert scale (*never*, *rarely*, *sometimes*, *often*, *very often*) in terms of frequency experienced in the preceding 30 days. Table 3.4 summarises the adjusted scoring of the items determined through a Rasch analysis (Heritage et al., 2018).

Table 3. 4
Summary of scoring of statements for the ProQOL-21 (Heritage et al., 2018)

ProQOL-21 subscale	ProQOL-5 item numbers	Scoring for responses *Never*; *Rarely*; *Sometimes*; *Often*; *Very often*
Compassion satisfaction	3, 12, 24, 27	11123
	6, 16, 18, 20, 22, 30	11234
Compassion fatigue	26	12233
	23	12333
	8, 10, 11, 14, 25	12344
	9, 13, 19, 21	12345

Heritage et al. (2018) reported a Cronbach's alpha value of .90 for both the compassion satisfaction and compassion fatigue subscales in a sample of 1615 registered nurses. Table 3.5 shows the reliability statistics for the ProQOL-21 obtained in this study.

Table 3. 5
Reliability statistics of ProQOL-21

Subscale	Number of items	Sample size	Cronbach's alpha
Compassion satisfaction	10	238	.901
Compassion fatigue	11	238	.845
ProQOL-21 overall	21	238	.680

Both the subscales demonstrate good internal consistency as indicated by their Cronbach's alpha values being higher than .70 (Christensen et al., 2015). As the ProQOL-21 is a multidimensional measure, Cronbach's alpha for the overall measure underestimates its reliability (Widhiarso & Ravand, 2014) − the value of .680 is therefore not a reason for concern.

3.4.1.3 Copenhagen Burnout Inventory.

This study used the Copenhagen Burnout Inventory (CBI) (Kristensen et al., 2005) to obtain independent measures of burnout. The CBI was developed by Kristensen et al. (2005) to reflect fatigue and exhaustion as the theoretical foundation of burnout, while distinguishing between burnout that an individual attributes to the personal, work, and client domains.

The CBI is a 21-question measure with three subscales measuring personal burnout (6 items), work-related burnout (7 items), and client-related burnout (6 items). Examples of items include "How often do you feel worn out?" (personal burnout), "Is your work emotionally exhausting?" (work-related burnout), and "Does it drain your energy to work with clients?" (client-related burnout).

The response categories for the 5-point Likert scales indicate either frequency (100 = *Always*, 75 = *Often*, 50 = *Sometimes*, 25 = *Seldom*, 0 = *Never/Almost never*) or extent (100 = *To a very high degree*, 75 = *To a high degree*, 50 = *Somewhat*, 25 = *To a low degree*, 0 = *To a very low degree*). Only one question is reverse scored.

The Cronbach's alpha values reported by Kristensen et al. (2005) are .87 for personal burnout, .87 for work-related burnout, and .85 for client-related burnout in a sample of 1914 participants from seven different human service occupations. Table 3.6 presents the reliability statistics for the CBI obtained in the present study. These coefficients show high internal reliability.

Table 3. 6
Reliability statistics of CBI

Subscale	Number of items	Sample size	Cronbach's alpha
Personal burnout	6	238	.889
Work-related burnout	7	238	.886
Client-related burnout	6	238	.852
CBI overall	19	238	.950

3.4.1.4 Self-care Assessment for Psychologists.

The Self-care Assessment for Psychologists (SCAP) (Dorociak et al., 2017a) assesses five dimensions of self-care with 21 items. Each statement is rated according to frequency of engaging in the behaviour on a scale of 1 (*never*) to 7 (*almost always*). The respective dimensions (and reported Cronbach's alpha) among a sample of 422 psychologists are professional support (.83), professional development (.80), life balance (.81), cognitive awareness (.72), and daily balance (.70) (Dorociak et al., 2017a). Example statements are: "I share work-related stressors with trusted colleagues." (professional support), "I find ways to stay current in professional knowledge." (professional development), "I seek out activities or people that are comforting to me." (life balance), "I monitor my feelings and reactions to clients." (cognitive awareness), and "I take breaks throughout the workday." (daily balance). Table 3.7 reports the reliability statistics for the SCAP results obtained in this study.

Table 3. 7
Reliability statistics of SCAP

Subscale	Number of items	Sample size[a]	Cronbach's alpha
Professional support	5	237	.836
Professional development	5	238	.828
Life balance	4	236	.873
Cognitive awareness	4	238	.823
Daily balance	3	238	.800
SCAP overall	21	235	.917

[a] Responses with missing data were excluded in the calculation of Cronbach's alpha.

Even though physical self-care is essential, the SCAP does not contain items for physical self-care practices due to possible individual variations (Dorociak et al., 2017a). The researcher inserted a checklist of additional general self-care practices after the SCAP questionnaire. The list included body treatments (e.g. massage), drinking several glasses of water each day, healthy food choices, movement/physical exercise, regular meals, sleeping at least 7 hours per night, spiritual and/or religious practices, stretch exercises, and time spent outdoors. Participants selected those practices that they regularly employed and could also add other practices. The inserted checklist was therefore not an assessment, but served to obtain an indication of participants' application of these practices.

3.4.2 Qualitative data collection instrument.

Semi-structured interviews served as the data collection instrument to gather qualitative data to contribute to understanding the quantitative data. Semi-structured interviews provide the advantage of having some open-ended questions to guide the interview, while allowing for responses from the participant to elicit follow-up questions for clarification (Willig, 2013). Six participants from the quantitative phase were interviewed.

Questions were compiled in advance as a guide for the interviews. The questions were directed at exploring the participants' subjective experiences relating to the constructs

assessed in the online questionnaire. The interview guide is included in Appendix C. The interviews served to obtain insight into participants' experiences as psychologists, beyond that provided by the quantitative data.

3.5 Data Collection Procedure

3.5.1 Quantitative data collection.

The quantitative questionnaires were completed online. To facilitate the online collection of quantitative data, the researcher created a Google Forms questionnaire. The first page of the online questionnaire contained the informed consent text, followed by the biographical questions and the quantitative measurement instruments. A reminder email was sent a week after the invitations were sent, and responses were accepted for 2 weeks after the invitations were sent. The completed responses were downloaded in a Microsoft Excel spreadsheet.

3.5.2 Qualitative data collection.

Interviews were conducted online on the Zoom platform and lasted between 45 minutes and an hour. The advantage of conducting the interviews online was not being geographically restricted in the selection of participants. The researcher arranged a convenient date and time with each participant who agreed to take part in this phase. An email sent to each participant contained the Zoom meeting invitation with a link for the appointed time. The researcher conducted the interviews from a room that was private and free from interruptions. With the consent of each participant, the interviews were recorded using the online platform.

3.6 Data analysis

3.6.1 Quantitative data analysis.

Quantitative data analyses were conducted using SPSS® Version 26. The statistical analyses of the quantitative data included descriptive statistics to describe the constructs under investigation and correlational analyses to investigate both the correlations between the constructs (Pearson's correlation coefficient) and how these constructs relate to each career group (Spearman's correlation coefficient). Multivariate analyses of variance (MANOVAs) were also used to search for differences between the different career groups and the constructs measured during the quantitative phase. Standard multiple regression analyses were conducted to determine which of the constructs predicted compassion fatigue.

3.6.2 Qualitative data analysis.

The researcher transcribed the recorded interviews. Table 3.8 shows the notation used in the transcriptions to indicate nuances in speech.

Table 3. 8
Transcription notation used in this study

Notation	Description
…	Section omitted in excerpt or speaker's voice trails off
*	Replaces vowel in offensive word
(Laughs)	Non-verbal communication: laughter
(Pause)	Distinctly longer pause
(Inaudible)	Words could not be distinguished
[ ]	Clarification of context or grammar

The transcriptions were analysed using inductive thematic analysis, an approach that allows the data to guide the identification of themes (Braun & Clarke, 2006). Using this process, a coding frame can be developed from the data, as opposed to working from an already established coding frame (Willig, 2013). Braun and Clarke's (2006) six phases guided the systematic process of thematic analysis. These phases are listed in Table 3.9.

Table 3. 9
Six phases used in the thematic analysis

Phase	Description
1	Familiarisation with the data by reading the interview transcripts while searching for possible patterns
2	Producing initial codes
3	Searching for themes from combinations of codes
4	Reviewing and refining the themes in relation to the complete data set
5	Defining and naming the final themes identified
6	Writing the final report

As explained earlier in this chapter (see 3.2), the emphasis of this research project is on the quantitative data of the first phase. The qualitative phase served to expand on and explain the numeric data. The results from the quantitative and qualitative phases of the study are discussed in Chapters 4 and 5 respectively.

3.7 Research quality

Onwuegbuzie and Johnson (2006) favour the term legitimation to represent validity in mixed methods research that yields dependable and credible inferences. In order to ensure research quality, this study employed certain strategies.

The quantitative phase utilised validated assessment measures to assess constructs under investigation (see 3.4), providing construct validity (Christensen et al., 2015).

In terms of the qualitative data, the interviews were transcribed verbatim and the results reported contained direct quotes. These quotes, referred to as low-inference descriptors, supply interpretive validity (Christensen et al., 2015) by ensuring partitipcants' words are correctly reported. Using the stepwise method suggested by Braun and Clarke (2006) for the thematic analysis contributed to the credibility of the qualitative results from the data. Furthermore, trustworthiness of the qualitative analysis was achieved by integrating the quantitative data collected in the first phase with the qualitative results.

3.8 Ethical Considerations

Ethical approval for this study was obtained from the Ethics Committee of the Faculty of Humanities, University of Pretoria (see Appendix D).

Information detailing the purpose, procedures, risks, benefits, and confidentiality aspects of the quantitative phase of the study was included in the emailed invitations (see Appendix A). Informed consent was electronically obtained via the online platform containing the questionnaire.

An emailed invitation, information letter, and informed consent form for the qualitative phase conveyed the purpose of the interview, procedures, risks, benefits, and confidentiality to those participants who were invited to participate in this phase (see Appendix B). Invitees were reminded that participation in the interviews was voluntary and that withdrawal at any stage was possible. The consent form contained the participant number allocated in the quantitative phase. The six participants returned completed informed consent forms via email.

To ensure confidentiality, all potential quantitative phase participants were assigned a numeric code in an encrypted spreadsheet. No identifying data were entered online by the participants. The responses used for further statistical analysis were listed only as codes. Using these codes, the researcher could identify participants from the recorded quantitative responses for the purpose of selecting interview participants. Interview participants' privacy was protected by assigning pseudonyms and altering identifying details.

No incentives were offered for participation in either the quantitative or qualitative phase of the study. Participants were informed that the de-identified data would be stored for a minimum of 15 years at the Department of Psychology at the University of Pretoria.

3.9 Conclusion

Chapter 3 describes the research design, sampling, measurement instruments, and data collection. It specifies the data analysis procedures of both phases and discusses ethical considerations.

Chapter 4 presents a detailed discussion on the results obtained in the quantitative phase.

CHAPTER 4: QUANTITATIVE RESULTS

4.1 Introduction

Chapter 4 reports the quantitative results of the study by means of descriptive statistics and inferential statistics. First, descriptive statistics are presented for the respective constructs measured. Then the results from parametric and non-parametric analyses detail the relationships among the constructs and biographic variables.

4.2 Descriptive Statistics

As stated in Chapter 3, the quantitative phase of this study features the ProQOL-21 (Heritage et al., 2018); the CBI (Kristensen et al., 2005); and the SCAP (Dorociak et al., 2017a).

The descriptive statistics include mean and standard deviation, minimum and maximum values, and valid number of cases for each assessment subscale. Where assessment measures recommend cut points, the distribution of cases is also presented.

4.2.1 Demographics.

The quantitative sample demographics are summarised in Chapter 3, Table 3.1. The biographical data collected on participants' professional background includes the age groups of clients, number of therapy sessions per week, and percentage of trauma therapy sessions. Table 4.1 lists these data, including the calculated number of trauma therapy sessions per week (see 3.4.1.1).

Table 4. 1
Additional biographical data per career stage and in total

Biographic variable	*n*	*M*	*SD*	Min	Max
Sessions per week					
Early career	85	19.99	9.31	0	50
Mid career	76	23.13	10.02	3	50
Late career	77	24.39	14.08	2	55
Total	238	22.42	11.39	0	55
Percentage of trauma sessions					
Early career	85	40.4	25.42	0	100
Mid career	76	38.8	24.98	0	100
Late career	77	35.5	25.32	0	100
Total	238	38.3	25.22	0	100
Trauma sessions per week (calculated)					
Early career	85	1.875	1.50	0	6.3
Mid career	76	5.484	3.74	0	18
Late career	77	9.805	7.58	0	36
Total	238	5.593	5.86	0	36

Percentage of psychologists working with the respective client age groups:

Career stage	*n*	Adults	Adolescents	Children
Early career	85	94.1%	77.6%	45.9%
Mid career	76	100.0%	60.5%	34.2%
Late career	77	100.0%	51.9%	28.6%
Total	238	97.9%	63.9%	36.6%

Note. Min = minimum; Max = maximum.

4.2.2 ProQOL-21.

The ProQOL-21 (Heritage et al., 2018) was used to assess compassion satisfaction and compassion fatigue. Heritage et al. (2018) converted raw scores to normed scores with a mean of 500 and a standard deviation of 100 and linked these to percentiles. The raw scores, normed scores, and percentiles were calculated for the sample. Table 4.2 presents the descriptive statistics of the raw scores and normed scores by career group and for the complete sample.

Table 4. 2
Descriptive statistics of the ProQOL-21 scores by career group and in total

ProQOL-21 subscale	*n*	Raw scores			Normed scores		
		Range	*M*	*SD*	Range	*M*	*SD*
Compassion satisfaction							
Early career	85	14-36	24.84	4.84	270-686	475.13	91.43
Mid career	76	10-35	26.25	5.61	195-667	501.87	106.12
Late career	77	15-36	27.51	5.15	289-686	525.61	97.33
Total	238	10-36	26.15	5.29	195-686	500	100
Compassion fatigue							
Early career	85	15-37	24.22	5.18	341-745	510.45	95.19
Mid career	76	14-45	24.54	5.89	322-893	516.26	108.34
Late career	77	13-39	22.16	4.99	304-782	472.42	91.81
Total	238	13-45	23.66	5.44	304-893	500	100

The assessment of compassion satisfaction and compassion fatigue is meant as a screening tool and should not be interpreted as diagnostic (Stamm, The concise ProQOL manual, 2010). In keeping with Stamm's (2010) recommendation, Heritage et al. (2018) applied the 25th and 75th percentiles as cut points to represent assessment scores possibly linked to relative risk or protective factors. Table 4.3 lists the raw scores obtained from the sample in this study and the ProQOL-21 raw scores linked to the 25th and 75th percentiles.

Table 4. 3
ProQOL-21 raw scores for bottom quartile, mean, and top quartile

Percentile	Compassion satisfaction raw score		Compassion fatigue raw score	
	Current study (*n* = 238)	Heritage et al. (2018) (*n* = 1615)	Current study (*n* = 238)	Heritage et al. (2018) (*n* = 1615)
25th	23	21	20	16 (female), 15 (male)
50th	26	26	23	20
75th	30	30	27	25

As can be seen in Table 4.3, the compassion satisfaction scores calculated from the data of this study are very similar to those obtained by Heritage et al. (2018) with Australian nurses. However, the compassion fatigue scores are higher for all percentiles, indicating a

higher distribution of compassion fatigue scores among the South African psychologists who participated in this study.

Next, Table 4.4 summarises the number of participants who scored lower than the 25th percentile and higher than the 75th percentile for the two subscales of the ProQOL-21. The distribution of these scores among the career stages is also included in Table 4.4.

Table 4. 4
Number of participants with ProQOL-21subscale scores below the 25th percentile and above the 75th percentile by career stage and in total

Career stage	*n*	Compassion satisfaction		Compassion fatigue	
		<25th percentile	>75th percentile	<25th percentile	>75th percentile
Early	85	24	12	17	25
Mid	76	19	19	16	22
Late	77	11	24	24	10
Total	238	54	55	57	57

The numbers in Table 4.4 were converted to show the percentage of participants in each career group. These percentages are graphically displayed in Figures 4.1 and 4.2. The colours in the figures were chosen to contrast possible "at risk" scores (red) and "protective factor" scores (green) respectively.

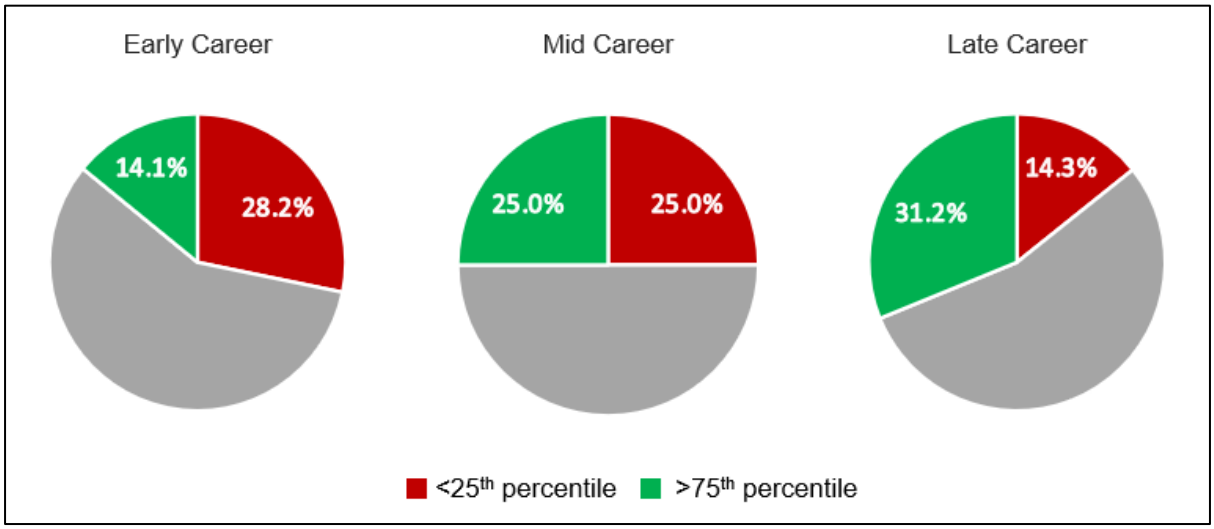

Figure 4. 1. Percentages of participants with compassion satisfaction scores above and below cut points by career group.

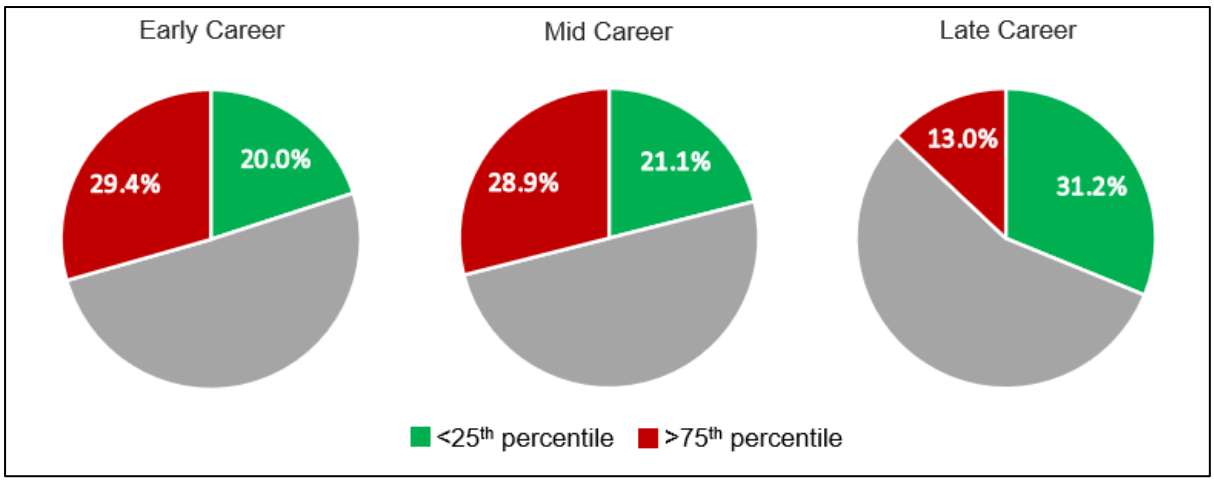

Figure 4. 2. Percentages of participants with compassion fatigue scores above and below cut points by career group.

4.2.3 Copenhagen Burnout Inventory (CBI).

Table 4.5 displays the descriptive statistics of personal, work-related, client-related, and overall burnout scores are displayed per career group and for the complete sample. The maximum score on each subscale is 100. From Table 4.5 it is evident that the mean score for personal burnout is the highest, followed by work-related burnout and then client-related burnout, a pattern found overall and in each of the career groups.

The number of participants with moderate burnout scores (50-74) and high burnout scores (75-99) per career group are indicated in Table 4.6. Then Figure 4.3 depicts the prevalence of moderate and high burnout per subscale by career group and for the complete sample. The total prevalence of moderate and high burnout is 42.4%, 29.4%, and 17.6% for personal, work-related, and client-related burnout respectively.

Table 4. 5
Descriptive statistics of the CBI subscale scores by career stage and in total

CBI Subscale	*n*	*M*	*SD*	Minimum	Maximum
PBO					
Early career	85	47.06	17.20	16.67	87.50
Mid career	76	49.18	18.22	16.67	91.67
Late career	77	39.83	16.63	4.17	87.50
Total	238	45.40	17.73	4.17	91.67
WBO					
Early career	85	43.19	15.38	10.71	78.57
Mid career	76	42.11	19.70	10.71	85.71
Late career	77	34.32	18.41	0.00	82.14
Total	238	39.98	18.19	0.00	85.71
CBO					
Early career	85	35.15	16.22	0.00	75.00
Mid career	76	31.41	19.35	0.00	83.33
Late career	77	27.49	16.68	0.00	70.83
Total	238	31.48	17.63	0.00	83.33
Overall burnout [a]					
Early career	85	41.80	14.92	18.85	77.58
Mid career	76	40.90	17.88	12.90	85.71
Late career	77	33.88	16.30	2.58	77.58
Total	238	38.95	16.67	2.579	85.714

Note. PBO = personal burnout; WBO = work-related burnout; CBO = client-related burnout.
[a] Calculated as average of the subscale scores.

Table 4. 6
Number of participants with moderate and high burnout scores on the CBI subscales by career stage and in total

Career group	*n*	PBO		WBO		CBO		Overall burnout	
		Moderate	High	Moderate	High	Moderate	High	Moderate	High
Early	85	34	7	25	4	17	1	22	2
Mid	76	28	9	23	5	11	3	15	6
Late	77	20	3	9	4	10	0	9	3
Total	238	82	19	57	13	38	4	46	11

Note. PBO = personal burnout; WBO = work-related burnout; CBO = client-related burnout.

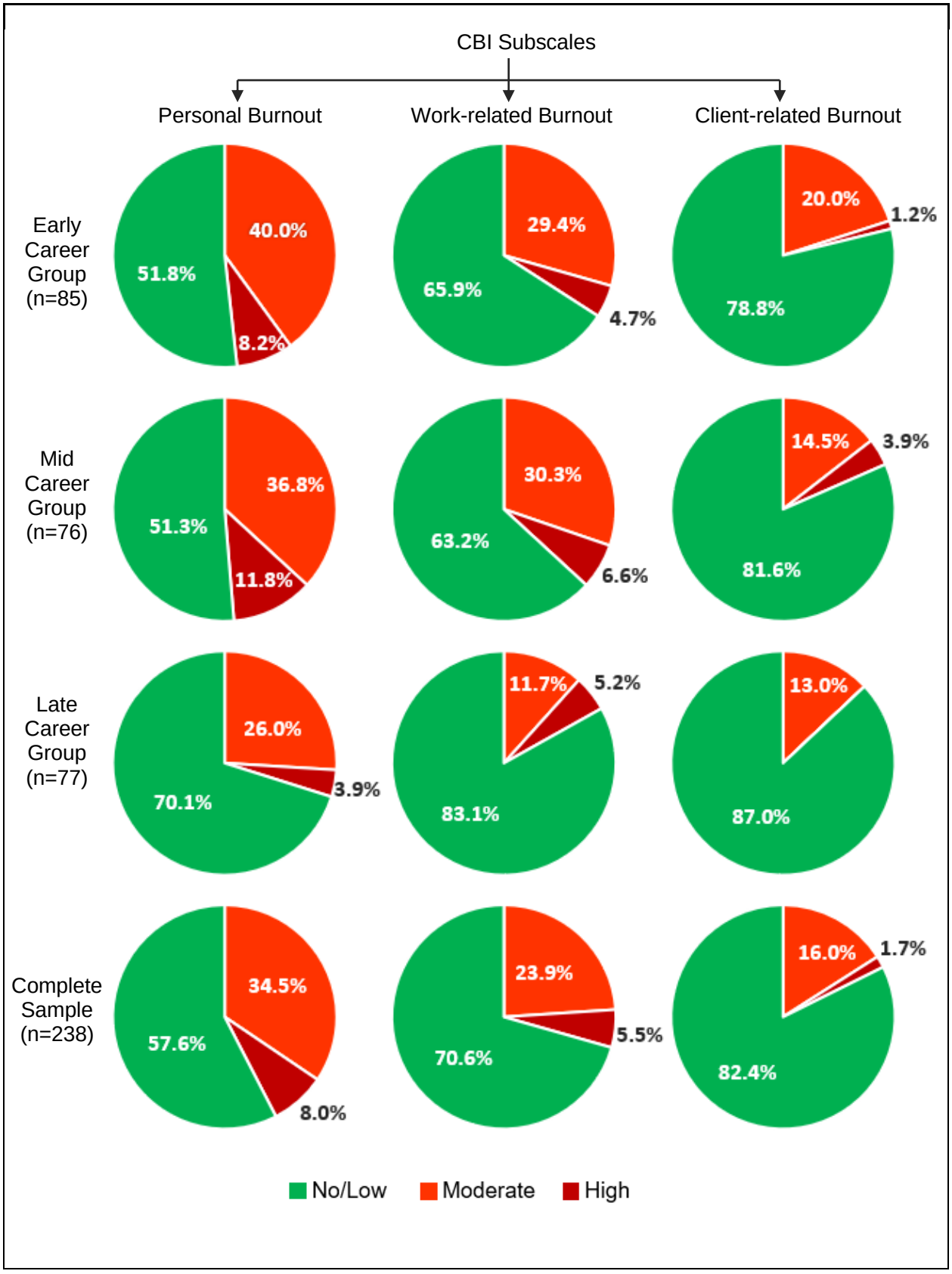

Figure 4. 3. Percentages of no/low, moderate and high burnout scores on the subscales of the CBI (Kristensen et al., 2005) by career group and for the complete sample.

4.2.4 Self-Care Assessment for Psychologists (SCAP).

The descriptive statistics of subscales scores from the SCAP questionnaire are listed in Table 4.7. As described in 3.4.1.4, the possible scores for each of the subscales ranges from 1 to 7.

Table 4. 7
Descriptive statistics of the SCAP scores by career group and in total

SCAP subscale	*n*	*M*	*SD*	Minimum	Maximum
Professional support					
Early career	85	4.97	1.30	1.80	7.00
Mid career	76	5.15	1.20	1.80	7.00
Late career	77	4.77	1.27	1.00	6.80
Total	238	4.96	1.26	1.00	7.00
Professional development					
Early career	85	4.91	1.23	2.00	7.00
Mid career	76	5.12	1.09	2.60	7.00
Late career	77	4.84	1.19	1.60	6.80
Total	238	4.96	1.18	1.60	7.00
Life balance					
Early career	85	5.64	1.11	1.75	7.00
Mid career	76	5.75	1.14	2.25	7.00
Late career	77	5.76	0.91	3.50	7.00
Total	238	5.71	1.06	1.75	7.00
Cognitive awareness					
Early career	85	5.75	0.88	2.75	7.00
Mid career	76	5.84	0.91	3.00	7.00
Late career	77	6.01	0.74	4.00	7.00
Total	238	5.86	0.85	2.75	7.00
Daily balance					
Early career	85	4.78	1.40	1.33	7.00
Mid career	76	4.77	1.59	1.67	7.00
Late career	77	5.10	1.49	1.67	7.00
Total	238	4.88	1.49	1.33	7.00

The SCAP subscale scores per career group are indicated as percentages of the maximum score in Figure 4.4.

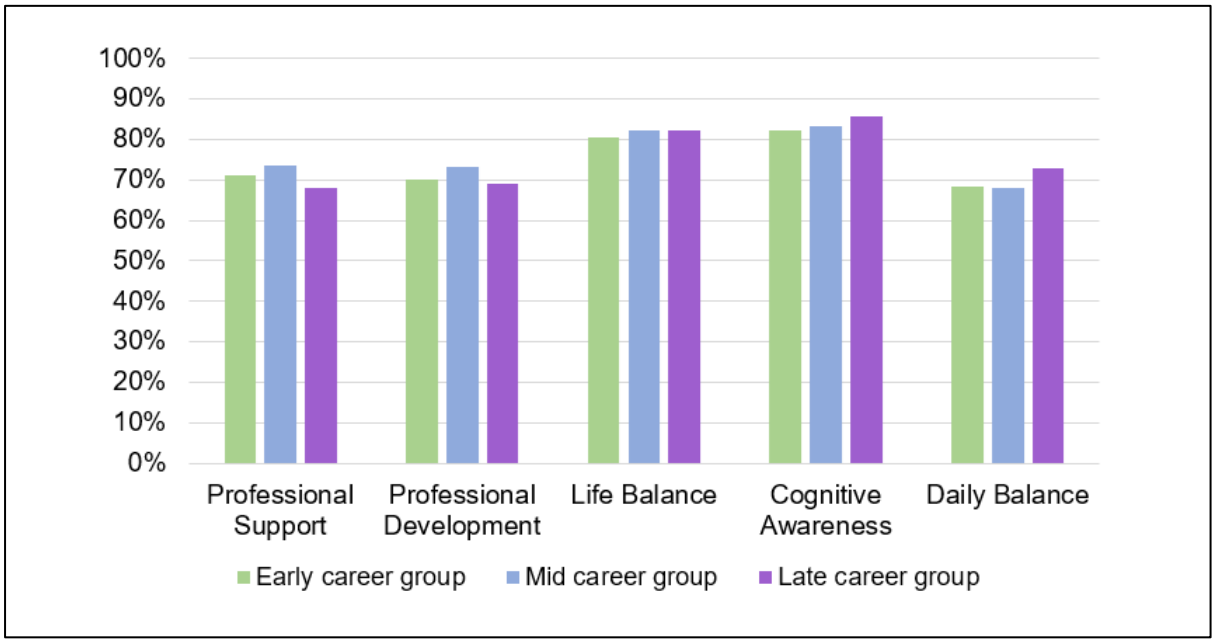

Figure 4. 4. SCAP subscale scores per career group expressed in percentage of the maximum score.

Dorociak et al. (2017a) found that the dimensions of self-care assessed by the SCAP subscales should be considered independently rather than combined into a single self-care score.

As discussed in 3.4.1.4, the checklist of additional self-care practices included in the online questionnaire do not form part of the SCAP. For the sake of completeness, Appendix E summarises these responses per career group.

4.3 Correlations

One of the objectives of this study (see 1.4) was to explore relationships among measures of compassion satisfaction, compassion fatigue, burnout, self-care, and weekly trauma therapy sessions. To achieve this objective, both the Pearson product-moment correlation and Spearman's rank order correlation were calculated. The results are reported in this section.

4.3.1 Parametric correlations.

The relationships among the measured constructs and the relevant biographical data were investigated utilising Pearson product-moment correlation coefficient calculations. This analysis was justified by the random sample of more than 30 cases, which made the requirement for normally distributed data negligible (Levin & Fox, 2014). Table 4.8 presents the Pearson correlation coefficients among the measured constructs and biographic variables. See Appendix F for a colour-coded display of the strength and direction of the correlation coefficients.

Table 4. 8
Correlations among scores from the ProQOL-21, CBI and SCAP for the complete sample (n=238)

Variable	CS	CF	PBO	WBO	CBO	PSup	PDev	LB	CogA	DB
Years	.248**	-.178**	-.187**	-.235**	-.206**	-0.034	0.040	0.073	.170**	0.123
S/w	-0.015	0.122	.232**	.287**	.173**	-0.029	0.002	-.139*	-0.112	-.454**
TS/w	-0.006	.293**	.281**	.285**	.198**	0.002	0.066	-.128*	-0.117	-.357**
CS	1	-.401**	-.421**	-.534**	-.600**	.218**	.284**	.349**	.398**	.237**
CF	-.401**	1	.730**	.744**	.691**	-.150*	-0.126	-.397**	-.340**	-.378**
PBO	-.421**	.730**	1	.882**	.723**	-.171**	-.222**	-.437**	-.385**	-.521**
WBO	-.534**	.744**	.882**	1	.816**	-.237**	-.294**	-.459**	-.437**	-.528**
CBO	-.600**	.691**	.723**	.816**	1	-.280**	-.306**	-.396**	-.422**	-.388**
PSup	.218**	-.150*	-.171**	-.237**	-.280**	1	.748**	.476**	.521**	.272**
PDev	.284**	-0.126	-.222**	-.294**	-.306**	.748**	1	.447**	.507**	.272**
LB	.349**	-.397**	-.437**	-.459**	-.396**	.476**	.447**	1	.650**	.538**
CogA	.398**	-.340**	-.385**	-.437**	-.422**	.521**	.507**	.650**	1	.572**
DB	.237**	-.378**	-.521**	-.528**	-.388**	.272**	.272**	.538**	.572**	1

Note. Years = number of years practising as a registered psychologist; S/w = average number of therapy sessions per week in the preceding six months; TS/w = average number of trauma therapy sessions per week in the preceding six months; CS = compassion satisfaction; CF = compassion fatigue: PBO = personal burnout: WBO = work-related burnout: CBO = client-related burnout; PSup = professional support; PDev = professional development; LB = life balance; CogA = cognitive awareness; DB = daily balance.
* Correlation is significant at the 0.05 level (2-tailed).
** Correlation is significant at the 0.01 level (2-tailed).

Table 4.8 shows several statistically significant correlations among the variables, including positive relationships between compassion satisfaction and the self-care subscales. As reasonably expected, negative relationships were found between the positive measures (compassion satisfaction and self-care) and both compassion fatigue and the burnout subscales. In addition, years of practice were significantly positively related to compassion satisfaction, and negatively to compassion fatigue and the burnout subscales. Therapy sessions per week and trauma therapy sessions per week were significantly associated with the burnout subscales, while only trauma therapy sessions per week showed a significant positive correlation with compassion fatigue.

4.3.2 Non-parametric correlations.

Spearman's rank order correlation was used to calculate the strength and significance of the relationships between career stage and the respective constructs measured in the quantitative phase. This non-parametric test requires that the variables compared are at least ordinal (Pallant, 2005). Table 4.9 lists the results of these calculations and the statistical significance of the correlation coefficients obtained.

Table 4.9 indicates that compassion satisfaction is significantly positively correlated with career stage, while compassion fatigue and all the burnout subscales are significantly negatively correlated with career stage. None of the subscales of the SCAP yielded statistically significant correlations with career stage.

Table 4. 9
Spearman's rank order correlation between career stage and constructs assessed (n = 238)

	Subscale		Career stage
Spearman's rho	Compassion satisfaction	Correlation coefficient Sig. (2-tailed)	.216** 0.001
	Compassion fatigue	Correlation coefficient Sig. (2-tailed)	-.152* 0.019
	Personal burnout	Correlation coefficient Sig. (2-tailed)	-.165* 0.011
	Work-related burnout	Correlation coefficient Sig. (2-tailed)	-.217** 0.001
	Client-related burnout	Correlation coefficient Sig. (2-tailed)	-.202** 0.002
	Professional support	Correlation coefficient Sig. (2-tailed)	-0.079 0.224
	Professional development	Correlation coefficient Sig. (2-tailed)	-0.022 0.730
	Life balance	Correlation coefficient Sig. (2-tailed)	0.028 0.669
	Cognitive awareness	Correlation coefficient Sig. (2-tailed)	0.124 0.056
	Daily balance	Correlation coefficient Sig. (2-tailed)	0.100 0.123

Note. Career stage = early, mid and late career.
* Correlation is significant at the 0.05 level (2-tailed).
** Correlation is significant at the 0.01 level (2-tailed).

4.4 Multivariate Analysis of Variance (MANOVA) by Career Stage

Since the Spearman's correlation showed significant relationships between career stage and some of the constructs assessed, the next step was to investigate whether significant differences exist among the different career stage groups with regards to the scores of the ProQOL-21, CBI and SCAP respectively. To reduce the risk of a Type I error – incorrectly finding a significant result – MANOVAs (multivariate analyses of variance) were performed.

4.4.1 MANOVA for ProQOL-21 subscales.

This analysis determined whether the early, mid and late career groups differ in levels of compassion satisfaction and compassion fatigue. The descriptive statistics of the subscale scores for the ProQOL-21 are reported in Table 4.2.

Multivariate tests determined whether there were significant differences among the early, mid, and late career groups on the subscale scores of the ProQOL-21. Table 4.10 lists the results of the multivariate tests for the ProQOL-21 subscales.

Table 4. 10
Multivariate tests[a] for the ProQOL-21 subscales

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial eta squared
Intercept	Pillai's trace	.987	8614.992[b]	2.000	234.000	.000	.987
	Wilks' lambda	.013	8614.992[b]	2.000	234.000	.000	.987
	Hotelling's trace	73.632	8614.992[b]	2.000	234.000	.000	.987
	Roy's largest root	73.632	8614.992[b]	2.000	234.000	.000	.987
Career stage	Pillai's trace	.066	4.026	4.000	470.000	.003	.033
	Wilks' lambda	.934	4.031[b]	4.000	468.000	.003[d]	.033
	Hotelling's trace	.069	4.036	4.000	466.000	.003	.033
	Roy's largest root	.054	6.377[c]	2.000	235.000	.002	.051

[a] Design: Intercept + Career stage.
[b] Exact statistic.
[c] The statistic is an upper bound on F that yields a lower bound on the significance level.
[d] Significance level linked to Wilks' lambda.

When interpreting the output of the multivariate tests in Table 4.10, Wilks' lambda is one of the statistics most commonly reported (Pallant, 2005). The significance value of Wilks' lambda in Table 4.10 indicates that there were statistically significant differences in compassion fatigue and compassion satisfaction scores among the early, mid, and late career groups.

Since the multivariate tests produced statistically significant results, between-subjects effects were then investigated. The alpha level was adjusted using the Bonferroni adjustment

(Pallant, 2005), which involved dividing the original .05 alpha level by the number of subscales. The adjusted significance value was therefore set at .025. The results of this investigation are presented in Table 4.11, which indicates statistically significant differences among early, mid and late career groups on scores for compassion satisfaction and compassion fatigue.

Table 4. 11
Tests of between-subjects effects of ProQOL-21 scores by career stage

Source	DV	Type III sum of squares	df	Mean square	F	Sig.	Partial eta squared
Corrected model	CS	289.364[a]	2	144.682	5.358	.005	.044
	CF	259.984[b]	2	129.992	4.527	.012	.037
Intercept	CS	162931.470	1	162931.470	6034.317	.000	.963
	CF	132670.381	1	132670.381	4620.425	.000	.952
Career stage	CS	289.364	2	144.682	5.358	.005[c]	.044
	CF	259.984	2	129.992	4.527	.012[c]	.037
Error	CS	6345.191	235	27.001			
	CF	6747.764	235	28.714			
Total	CS	169400.000	238				
	CF	140188.000	238				
Corrected total	CS	6634.555	237				
	CF	7007.748	237				

Note. DV = dependent variable; CS = compassion satisfaction; CF = compassion fatigue.
[a] R squared = .044 (Adjusted R squared = .035).
[b] R squared = .037 (Adjusted R squared = .029).
[c] Values compared to Bonferroni-adjusted alpha level of .025.

The partial eta squared values obtained for compassion satisfaction (.044) and compassion fatigue (.037) indicate small effect sizes (Cohen, 1988).

As the next step in the MANOVA, group means were compared. Table 4.12 reports the estimated marginal means of the ProQOL-21 subscales for each career group.

Table 4. 12
Estimated marginal means for ProQOL-21 subscales by career stage

Dependent variable	Career stage	Mean	Std. error	95% confidence interval	
				Lower bound	Upper bound
Compassion satisfaction[a]	Early career group	24.835	.564	23.725	25.946
	Mid career group	26.250	.596	25.076	27.424
	Late career group	27.506	.592	26.340	28.673
Compassion fatigue[a]	Early career group	24.224	.581	23.078	25.369
	Mid career group	24.539	.615	23.329	25.750
	Late career group	22.156	.611	20.953	23.359

[a] Statistically significant dependent variables.

Since more than two groups were compared, pairwise comparisons determined how the groups differ from one another. Table 4.13 lists the results of the pairwise comparisons.

Table 4. 13
Pairwise comparisons for ProQOL-21 subscales by career stage

Dependent variable	(I) Career stage	(J) Career stage	Mean difference (I-J)	Std. error	Sig.[b]	95% confidence interval for difference[b]	
						Lower bound	Upper bound
Compassion satisfaction	Early	Mid	-1.415	.820	.258	-3.393	.563
		Late	-2.671*	.818	.004*	-4.642	-.700
	Mid	Early	1.415	.820	.258	-.563	3.393
		Late	-1.256	.840	.408	-3.282	.769
	Late	Early	2.671*	.818	.004*	.700	4.642
		Mid	1.256	.840	.408	-.769	3.282
Compassion fatigue	Early	Mid	-.316	.846	1.000	-2.356	1.724
		Late	2.068*	.843	.045*	.035	4.100
	Mid	Early	.316	.846	1.000	-1.724	2.356
		Late	2.384*	.866	.019*	.294	4.473
	Late	Early	-2.068*	.843	.045*	-4.100	-.035
		Mid	-2.384*	.866	.019*	-4.473	-.294

Note. Based on estimated marginal means.
* The mean difference is significant at the .05 level.
[b] Adjustment for multiple comparisons: Bonferroni.

From Table 4.13, it is clear that significant differences were found between the early and late career groups for compassion satisfaction and compassion fatigue. Between the mid and late career groups, significant differences were evident in compassion fatigue scores but not in compassion satisfaction scores. None of the differences between the early and mid career groups were significant.

4.4.2 MANOVA for CBI subscales.

This analysis determined whether early, mid and late career groups differ in terms of their levels of personal burnout, work-related burnout and client-related burnout. The descriptive statistics of the subscale scores for the CBI by career stage are reported in Table 4.5.

Multivariate tests determined whether there were significant differences among the early, mid, and late career groups on subscale scores of the CBI. Table 4.14 lists the results of these tests for the CBI subscales.

Table 4. 14
Multivariate tests[a] for the CBI subscales

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial eta squared
Intercept	Pillai's trace	.874	537.553[b]	3.000	233.000	.000	.874
	Wilks' lambda	.126	537.553[b]	3.000	233.000	.000	.874
	Hotelling's trace	6.921	537.553[b]	3.000	233.000	.000	.874
	Roy's largest root	6.921	537.553[b]	3.000	233.000	.000	.874
Career stage	Pillai's trace	.088	3.591	6.000	468.000	.002	.044
	Wilks' lambda	.914	3.580[b]	6.000	466.000	.002[d]	.044
	Hotelling's trace	.092	3.569	6.000	464.000	.002	.044
	Roy's largest root	.057	4.473[c]	3.000	234.000	.004	.054

[a] Design: Intercept + Career stage.
[b] Exact statistic.
[c] The statistic is an upper bound on F that yields a lower bound on the significance level.
[d] Significance level linked to Wilks' lambda.

The significance value of Wilks' lambda in Table 4.14 is less than .05. It can therefore be inferred that there were statistically significant differences in personal burnout, work-related burnout, and client-related burnout scores among the early, mid, and late career groups.

Since the multivariate tests produced significant results, between-subjects effects were investigated. The alpha level was adjusted using the Bonferroni adjustment, which involved dividing the original .05 alpha level by the number of subscales. The adjusted significance value was therefore set at .017 for the CBI subscales. Table 4.15 presents the results of this investigation.

Table 4. 15
Tests of between-subjects effects of CBI scores by career stage

Source	DV	Type III sum of squares	df	Mean square	F	Sig.	Partial eta squared
Corrected model	PBO	3710.076[a]	2	1855.038	6.159	.002	.050
	WBO	3685.190[b]	2	1842.595	5.793	.004	.047
	CBO	2369.700[c]	2	1184.850	3.904	.021	.032
Intercept	PBO	488351.594	1	488351.594	1621.500	.000	.873
	WBO	377457.550	1	377457.550	1186.698	.000	.835
	CBO	233332.266	1	233332.266	768.783	.000	.766
Career stage	PBO	3710.076	2	1855.038	6.159	.002[d]	.050
	WBO	3685.190	2	1842.595	5.793	.004[d]	.047
	CBO	2369.700	2	1184.850	3.904	.021[d]	.032
Error	PBO	70775.582	235	301.173			
	WBO	74747.326	235	318.074			
	CBO	71324.569	235	303.509			
Total	PBO	564947.917	238				
	WBO	458775.510	238				
	CBO	309513.889	238				
Corrected total	PBO	74485.659	237				
	WBO	78432.516	237				
	CBO	73694.269	237				

Note. DV = dependent variable; PBO = personal burnout; WBO = work-related burnout; CBO = client-related burnout.
[a] R squared = .050 (Adjusted R squared = .042).
[b] R squared = .047 (Adjusted R squared = .039).
[c] R squared = .032 (Adjusted R squared = .024).
[d] Values compared to Bonferroni-adjusted alpha level of .017.

The significance values in Table 4.15 indicate statistically significant differences among early, mid, and late career groups on scores for personal burnout and work-related burnout but not for client-related burnout. The partial eta squared values obtained for personal burnout (.050) and work-related burnout (.047) indicated small effect sizes (Cohen, 1988).

As the next step in the MANOVA, Table 4.16 reports the estimated marginal means of the CBI subscales for each career group.

Table 4. 16
Estimated marginal means for CBI subscales by career stage

Dependent variable	Career stage	Mean	Std. error	95% confidence interval	
				Lower bound	Upper bound
Personal burnout[a]	Early career group	47.059	1.882	43.350	50.767
	Mid career group	49.178	1.991	45.256	53.099
	Late career group	39.827	1.978	35.931	43.723
Work-related burnout[a]	Early career group	43.193	1.934	39.382	47.004
	Mid career group	42.105	2.046	38.075	46.136
	Late career group	34.323	2.032	30.319	38.327
Client-related burnout	Early career group	35.147	1.890	31.424	38.870
	Mid career group	31.414	1.998	27.477	35.352
	Late career group	27.489	1.985	23.578	31.401

[a] Statistically significant dependent variables.

Pairwise comparisons determined how the career groups differed from one another. Table 4.17 lists these pairwise comparisons for the CBI subscales. From Table 4.17 it is evident that significant mean differences were found between the early and late career groups for personal burnout, work-related burnout, and client-related burnout. Comparing mid and late career groups, the significant mean differences included personal burnout and work-related burnout. However, none of the mean differences for any of the CBI subscales were significant between the early and mid career groups.

Table 4. 17
Pairwise comparisons for CBI subscales by career stage

Dependent variable	(I) Career stage	(J) Career stage	Mean difference (I-J)	Std. error	Sig.[b]	95% confidence interval for difference[b]	
						Lower bound	Upper bound
Personal burnout	Early	Mid	-2.119	2.740	1.000	-8.725	4.487
		Late	7.232*	2.730	.026*	.649	13.815
	Mid	Early	2.119	2.740	1.000	-4.487	8.725
		Late	9.351*	2.806	.003*	2.585	16.117
	Late	Early	-7.232*	2.730	.026*	-13.815	-.649
		Mid	-9.351*	2.806	.003*	-16.117	-2.585
Work-related burnout	Early	Mid	1.088	2.816	1.000	-5.701	7.877
		Late	8.870*	2.806	.005*	2.105	15.636
	Mid	Early	-1.088	2.816	1.000	-7.877	5.701
		Late	7.782*	2.884	.022*	.829	14.736
	Late	Early	-8.870*	2.806	.005*	-15.636	-2.105
		Mid	-7.782*	2.884	.022*	-14.736	-.829
Client-related burnout	Early	Mid	3.733	2.750	.528	-2.899	10.364
		Late	7.658*	2.741	.017*	1.049	14.267
	Mid	Early	-3.733	2.750	.528	-10.364	2.899
		Late	3.925	2.817	.494	-2.867	10.718
	Late	Early	-7.658*	2.741	.017*	-14.267	-1.049
		Mid	-3.925	2.817	.494	-10.718	2.867

Note. Based on estimated marginal means.
* The mean difference is significant at the .05 level.
[b] Adjustment for multiple comparisons: Bonferroni.

4.4.3 MANOVA for SCAP subscales.

The MANOVA for the SCAP subscales aimed to confirm whether early, mid, and late career groups differed in terms of their levels of professional support, professional development, life balance, cognitive awareness, and daily balance. The descriptive statistics of the subscale scores for the SCAP by career stage are reported in Table 4.7.

Multivariate tests determined whether there were significant differences among the early, mid, and late career groups on the subscale scores of the SCAP. Table 4.18 lists the results of these tests for the SCAP subscales.

Table 4. 18
Multivariate tests[a] for the SCAP subscales

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial eta squared
Intercept	Pillai's trace	.981	2383.557[b]	5.000	231.000	.000	.981
	Wilks' lambda	.019	2383.557[b]	5.000	231.000	.000	.981
	Hotelling's trace	51.592	2383.557[b]	5.000	231.000	.000	.981
	Roy's largest root	51.592	2383.557[b]	5.000	231.000	.000	.981
Career stage	Pillai's trace	.062	1.477	10.000	464.000	.145	.031
	Wilks' lambda	.939	1.486[b]	10.000	462.000	.141[d]	.031
	Hotelling's trace	.065	1.495	10.000	460.000	.138	.031
	Roy's largest root	.059	2.731[c]	5.000	232.000	.020	.056

[a] Design: Intercept + Career stage.
[b] Exact statistic.
[c] The statistic is an upper bound on F that yields a lower bound on the significance level.
[d] Significance level linked to Wilks' lambda.

The output of the multivariate tests in Table 4.18 shows a Wilks' lambda significance level of more than .05. It can therefore be inferred that the differences of the SCAP subscale scores among the early, mid, and late career groups were not significant. This confirmed the non-significant result of the Spearman's correlation analysis (Table 4.9) and concluded the MANOVA for the SCAP subscales.

4.5 Standard Multiple Regression Statistics for predicting compassion fatigue.

Both positive and negative aspects were assessed by the quantitative measurements in this study. Standard multiple regression analyses were done to explore how well compassion fatigue can be predicted by compassion satisfaction, burnout, self-care, trauma therapy sessions per week, and career stage.

Preliminary analyses confirmed that the data complied with the requirements regarding normality, linearity, and multicollinearity.

4.5.1 Standard multiple regression including individual CBI subscales.

The first multiple regression analysis with compassion fatigue as dependent variable included the following independent variables: compassion satisfaction, the CBI subscales (personal burnout, work-related burnout, and client-related burnout), the SCAP subscales (professional support, professional development, life balance, cognitive awareness, and daily balance), career stage, and trauma therapy sessions per week. The late career stage was used as a reference for the other two career stages. Table 4.19 provides the model summary.

Table 4. 19
Model summary[b]

Model	R	R square	Adjusted R square	Std. error of the estimate
1	.793[a]	0.629	0.609	3.40035

[a] Predictors: (constant), CareerStage=Mid career group, client-related burnout, number of trauma therapy sessions per week, professional support, daily balance, CareerStage=Early career group, compassion satisfaction, life balance, cognitive awareness, professional development, personal burnout, work-related burnout.
[b] Dependent variable: compassion fatigue.

The R square value in Table 4.19 implies that the independent variables accounted for 62.9% of variance in compassion fatigue. Table 4.20 presents the evaluation of the significance of the results obtained, which indicates that the model reached statistical significance.

Table 4. 20
Statistical significance of model evaluation results

ANOVA[a]						
Model		Sum of squares	df	Mean square	F	Sig.
1	Regression	4406.218	12	367.185	31.757	.000[b]
	Residual	2601.530	225	11.562		
	Total	7007.748	237			

[a] Dependent variable: compassion fatigue
[b] Predictors: (constant), CareerStage=Mid career group, client-related burnout, number of trauma therapy sessions per week, professional support, daily balance, CareerStage=Early career group, compassion satisfaction, life balance, cognitive awareness, professional development, personal burnout, work-related burnout

Next, the significance and contribution of the predictor variables are reported. Table 4.21 lists the coefficients for each variable.

Table 4. 21
Coefficients[a] for standard multiple regression including CBI subscales

Model		Unstandardised coefficients		Std. coeff.	t	Sig.	95% confidence interval for B		Collinearity statistics	
		B	Std. error	Beta			Lower bound	Upper bound	Tol.	VIF
1	(Constant)	12.500	2.565		4.874	0.000	7.446	17.554		
	CS	0.027	0.055	0.026	0.484	0.629	-0.082	0.136	0.567	1.763
	PBO	0.088	0.028	0.286	3.180	0.002*	0.033	0.142	0.204	4.892
	WBO	0.082	0.032	0.273	2.544	0.012*	0.018	0.145	0.143	7.003
	CBO	0.084	0.024	0.273	3.573	0.000*	0.038	0.131	0.282	3.540
	PSup	-0.188	0.280	-0.044	-0.672	0.502	-0.740	0.364	0.390	2.567
	PDev	0.735	0.297	0.159	2.475	0.014*	0.150	1.321	0.400	2.498
	LB	-0.625	0.301	-0.122	-2.076	0.039*	-1.218	-0.032	0.480	2.081
	CogA	-0.193	0.404	-0.030	-0.476	0.634	-0.989	0.604	0.413	2.419
	DB	0.366	0.213	0.100	1.722	0.086	-0.053	0.786	0.485	2.064
	TS/w	0.061	0.032	0.086	1.887	0.061	-0.003	0.125	0.797	1.255
	Early career	0.146	0.562	0.013	0.260	0.795	-0.960	1.253	0.671	1.490
	Mid career	0.558	0.579	0.048	0.964	0.336	-0.583	1.700	0.666	1.502

Note. Std. coeff. = standardised coefficients; Tol. = tolerance; CS = compassion satisfaction; PBO = personal burnout; WBO = work-related burnout; CBO = client-related burnout; PSup = professional support; PDev = professional development; LB = life balance; CogA = cognitive awareness; DB = daily balance; TS/w = trauma therapy sessions per week; Early career = CareerStage=Early career group; Mid career = CareerStage=Mid career group
[a] Dependent variable: compassion fatigue.
* Significance < .05.

From the standardised beta coefficients in Table 4.21 it is apparent that personal burnout was the strongest predictor of compassion fatigue (beta = .286, $p < .05$), jointly followed by work-related burnout and client-related burnout (beta = .273, $p < .05$). Professional development also rendered a positive contribution (beta = .159, $p < .05$). The only remaining significant predictor variable was LB (beta = -.122, $p < .05$), which contributed the least.

4.5.2 Standard multiple regression including combined burnout score.

Considering the high association among the burnout subscales (see Table 4.8), an additional regression analysis was done. This analysis replaced the burnout subscales with a single burnout variable, calculated as the average of personal burnout, work-related burnout, and client-related burnout. This standard multiple regression analysis determined how well compassion fatigue was predicted by compassion satisfaction, average burnout, the SCAP subscales (personal burnout, work-related burnout, and client-related burnout), career stage, and trauma sessions per week. Table 4.22 provides the model summary.

Table 4. 22
Model summary[b]

Model	R	R square	Adjusted R square	Std. error of the estimate
1	.793[a]	0.629	0.612	3.38543

[a] Predictors: (constant), CareerStage=Mid career group, compassion satisfaction, number of trauma therapy sessions per week, professional support, daily balance, CareerStage=Early career group, life balance, burnout, cognitive awareness, professional development.
[b] Dependent variable: compassion fatigue.

As with the previous analysis, the R square value in Table 4.22 implies that the independent variables accounted for 62.9% of variance in compassion fatigue. Table 4.23 presents the evaluation of the significance of the results obtained, which indicates that this model also reached statistical significance.

Table 4. 23
Statistical significance of model evaluation results

ANOVA[a]						
Model		Sum of squares	df	Mean square	F	Sig.
1	Regression	4406.064	10	440.606	38.443	.000[b]
	Residual	2601.684	227	11.461		
	Total	7007.748	237			

[a] Dependent variable: compassion fatigue.
[b] Predictors: (constant), CareerStage=Mid career group, compassion satisfaction, number of trauma therapy sessions per week, professional support, daily balance, CareerStage=Early career group, life balance, burnout, cognitive strategies, professional development.

Next, the significance and contribution of each of the predictor variables were considered. Table 4.24 lists these results. From the standardised beta coefficients in Table 4.24 it is apparent that the combined burnout score was the greatest contributor (beta = .777, $p < .05$), followed by PDev (beta = .159, $p < .05$), and LB (beta = -.122, $p < .05$).

Table 4. 24
Coefficients[a] for standard multiple regression including average burnout score

Model		Unstandardised coefficients		Std. coeff.	t	Sig.	95% confidence interval for B		Collinearity statistics	
		B	Std. error	Beta			Lower bound	Upper bound	Tol.	VIF
1	(Constant)	12.474	2.543		4.905	0.000	7.463	17.485		
	CS	0.028	0.053	0.028	0.534	0.594	-0.076	0.133	0.616	1.624
	Burnout	0.254	0.019	0.777	13.460	0.000*	0.217	0.291	0.490	2.040
	PSup	-0.187	0.277	-0.043	-0.674	0.501	-0.732	0.359	0.396	2.528
	PDev	0.737	0.295	0.159	2.498	0.013*	0.156	1.318	0.403	2.484
	LB	-0.627	0.297	-0.122	-2.109	0.036*	-1.213	-0.041	0.487	2.052
	CogA	-0.191	0.401	-0.030	-0.477	0.634	-0.981	0.599	0.417	2.401
	DB	0.365	0.208	0.100	1.756	0.080	-0.045	0.775	0.502	1.990
	TS/w	0.061	0.032	0.086	1.893	0.060	-0.003	0.124	0.800	1.250
	Early career	0.144	0.558	0.013	0.258	0.797	-0.956	1.244	0.673	1.485
	Mid career	0.565	0.570	0.049	0.991	0.323	-0.558	1.687	0.683	1.465

Note. Std. coeff. = standardised coefficients; Tol. = tolerance; CS = compassion satisfaction; Burnout = average burnout; PSup = professional support; PDev = professional development; LB = life balance; CogA = cognitive awareness; DB = daily balance; TS/w = trauma therapy sessions per week; Early career = CareerStage=Early career group; Mid career = CareerStage=Mid career group.
[a] Dependent variable: compassion fatigue.
* Significance < .05.

4.8 Quantitative Results Relative to Research Problem

As described in 1.3, psychologists experience positive and negative aspects in their profession. Compassion satisfaction, compassion fatigue, burnout and self-care were assessed and compared for the different career stages. Compassion satisfaction and self-care demonstrated the expected positive relationship. Also anticipated, compassion fatigue and burnout were negatively related to both compassion satisfaction and self-care. Trauma therapy sessions per week were positively associated with compassion fatigue and burnout,

indicating that seeing trauma clients may affect these aspects of psychologists' professional quality of life. The number of therapy sessions had a positive relationship with burnout.

Significant differences were evident for compassion satisfaction, compassion fatigue, and burnout among the career groups. Standard multiple regression analyses demonstrated that the burnout subscales and overall burnout were significant predictors of compassion fatigue.

4.9 Conclusion

This chapter uses descriptive statistics and several statistical analyses to report the quantitative results of the data collected. The exploration of relationships among the constructs and biographic variables included correlations, MANOVAs and standard multiple regression.

Chapter 5 presents the results of the qualitative analysis of the interviews from the second phase of this study.

CHAPTER 5: QUALITATIVE RESULTS

5.1 Introduction

Chapter 5 presents the thematic analysis of the qualitative data collected in the second phase of this study (see 3.2). As mentioned in 3.6.2, the thematic analysis made use of the six phases of thematic analysis proposed by Braun and Clarke (2006). This chapter describes the process of the analysis and details the initial assignment of codes. Following this, the subthemes and subsequent themes identified from the interview data are discussed.

5.2 Qualitative Results: Inductive Thematic Analysis

In this section, an in-depth discussion is presented on the application of the six phases of Braun and Clarke (2006) within the context of the present study. Table 5.1 again lists the notation used in the excerpts as presented in 3.6.2.

Table 5. 1
Transcription notation used in this study

Notation	Description
…	Section omitted in excerpt or speaker's voice trails off
*	Replaces vowel in offensive word
(Laughs)	Non-verbal communication: laughter
(Pause)	Distinctly longer pause
(Inaudible)	Words could not be distinguished
[ ]	Clarification of context or grammar

5.2.1 Phase 1: Familiarisation with the data.

The first phase in thematic analysis is what Braun and Clarke (2006) referred to as familiarisation with the data. With this aim in mind, the researcher transcribed all six interviews from the audio recordings made (see 3.5.2). Transcribing the interviews involved listening to short segments at a time, typing the conversation from the segment, then replaying the segment to check the text. On completion of the transcript of each interview, the researcher listened to the complete recording while checking the transcript for accuracy.

During the transcription process, the researcher marked sections of text that were inaudible and words that could not be distinguished with certainty. The transcription served as the researcher's initial familiarisation with each of the interviews.

On completing the transcripts, the researcher read paper copies of the transcripts several times to refresh in her mind the content of each interview. This reading process enabled the researcher to start searching for possible patterns and to make some initial notes to use during the subsequent analysis.

5.2.2 Phase 2: Generating initial codes.

The second phase of the thematic analysis is the generation of initial codes (Braun & Clarke, 2006). Codes condense relevant phrases into meaning units that can be at a basic semantic or more interpretative level (Willig, 2013; Braun & Clarke, 2006). The researcher systematically analysed the printed copies of the transcripts. Segments of text that seemed to present basic meaning and patterns contained in the data were marked with a broad range of codes. The initial codes were generated without limitations based on the research question, aim and objectives of the study. This allowed the researcher to explore the data as widely as possible.

After the identification of initial codes from each transcript, the transcripts were reread with the variety of codes in mind. This process allowed the researcher to not only refine, rename, and merge certain codes but also discard codes that were not generally representative of the data set.

Table 5.2 presents an illustrative selection of the codes originally identified − each with a supporting data extract. All data extracts in this table and chapter are indicated according to the assigned pseudonyms (see 3.3.2).

Table 5. 2
Examples of initial codes

Code	Sample data extract
Attitude towards job	Michael: *"I love what I do, because every patient is different, no single one is the same. I get a lot of meaning from it, a lot of purpose from it …"*
Regulatory issues	Edith: *"There's issues with the scope of practice, the NHI, um, it's very uncertain, you know."*
Type of clients	Lilith: *"But your chronic trauma, your childhood trauma, early traumas, that's a completely different ballgame …"*
Therapy outcomes	Lionel: *"In my own practice I see the results of it [hypnosis]. The nice thing about it also, is that most of your clients and patients that you see, you don't have so many sessions."*
Experience of negative effects	Estell: *"It's like I'm, I'm present in body but not in mind so much. … I'm just going through the motions: get up, work, eat, go to sleep, repeat, repeat, repeat."*
Responsibility towards clients	Mitch: *"And, and when I'm then with a client, … in that time it is about the client. So in a way I, I put myself aside then."*
Practice management	Michael: *"I have a very good office manager that does that [administration] on my behalf, which takes a lot of load from my shoulders."*
Seasonal pattern	Lilith: *"Um, so generally from about mid January, end of January till Easter, is extremely difficult in practice. Medical aids are working again. Those that were delaying consultations will make appointments."*
Additional training	Edith: *"So when, you know, I went for the training, it literally changed my life. You know, where I had structure, I had guidance, I knew what I was doing, I feel confident in what I'm doing."*
Input from colleagues	Lionel: *"After certain traumatic experiences, I actually went to colleagues that obviously have the same approach that I do, and I've experienced that first-hand, you know, the effect of it."*
Self-compassion	Mitch: *"So I, I don't need to be this… ja, strong, 'in control' person anymore. I, I can just be me."*
Managing bookings	Estell: *"I am also aware that um, certain cases need to be scheduled around certain times of the day. If it's a, a difficult case I will place them before lunch, so that I have a break after that."*
Taking time out	Edith: *"You just need … ja, especially towards the end of the year, it's just, it's just, you just need that holiday …"*
Working hours	Lilith: *"So generally what you're looking at – and it's really not just me, it's people in practice, this is what we look at – you're starting at six, half past six in the morning. You are very lucky to walk out seven or later."*
Hobbies	Michael: *"I'm a bit of a birdwatcher, amateur birdwatcher."*
Personality	Edith: *"I'm an introvert … 'peopling' all day is absolutely exhausting, it drains, drains and drains. But that's my personality type, not only the nature of the job."*
Household setting	Lionel: *"I think I do have that me-time, fortunately our children have left the home now … "*

5.2.3 Phase 3: Searching for themes.

According to Willig (2013, p. 58), "a theme refers to a particular, recognizable configuration of meanings which co-occur in a way that is meaningful and systematic rather than random and arbitrary." As themes are broader units of meaning than codes (Braun & Clarke, 2006), the researcher considered combinations of the coded extracts generated in the previous phase to produce possible themes. The development of themes from codes involves progressing from simple descriptions to a level of interpretation (Willig, 2013). This phase included portraying codes and subthemes on a preliminary schematic map, as presented in Figure 5.1.

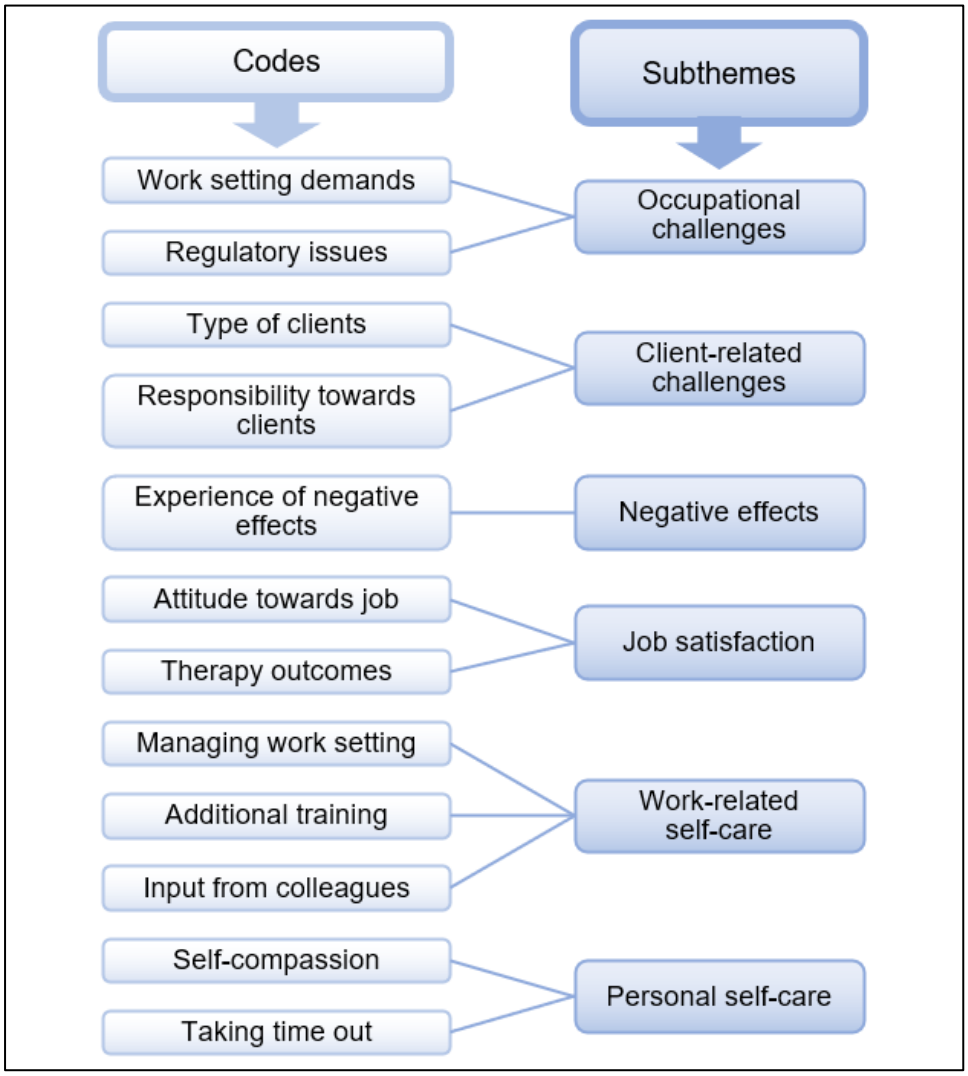

Figure 5. 1. Overview of refined codes and preliminary themes.

5.2.4 Phase 4: Reviewing themes.

The subthemes identified in Phase 3 were reviewed and further refined by considering how these themes were represented in the data (Braun & Clarke, 2006) and the relevance of each theme in terms of the research question (Willig, 2013). Some of the subthemes dealing with a shared feature were grouped and one was renamed. Figure 5.2 presents the revised thematic map with the final themes and subthemes.

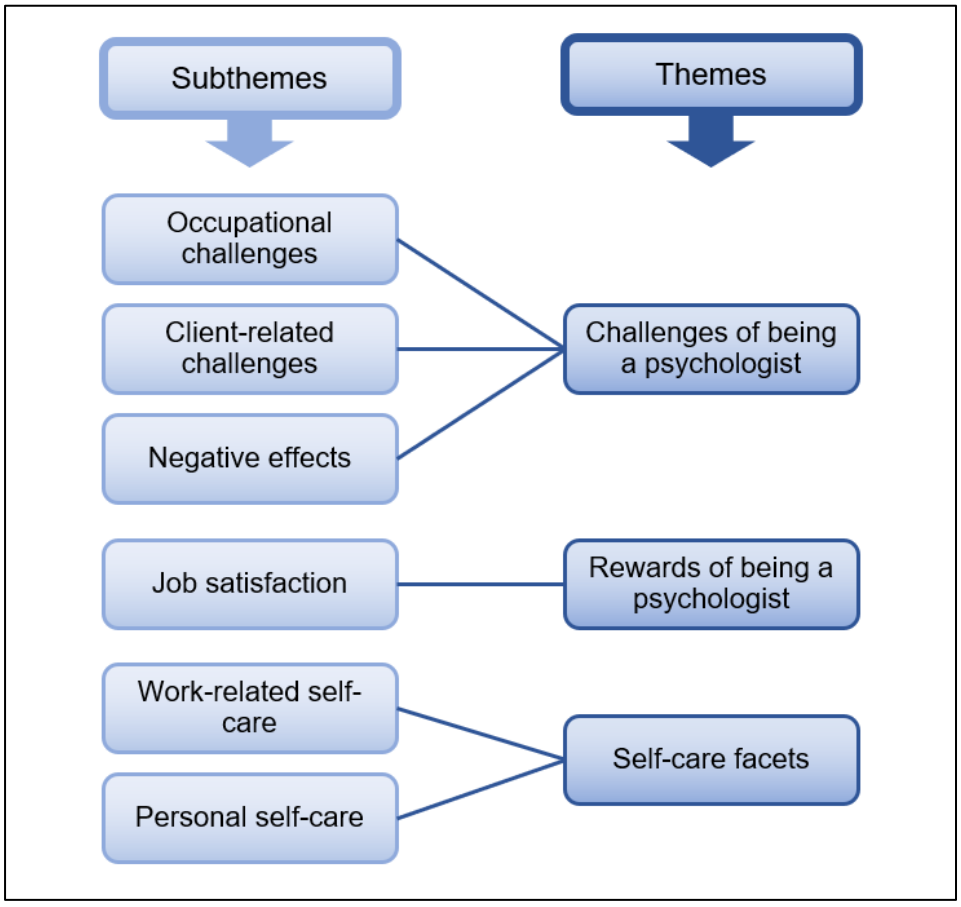

Figure 5. 2. Overview of the final themes and subthemes.

5.2.5 Phase 5: Defining and naming themes.

Braun and Clarke (2006) recommended establishing the essence of what each theme represents in this phase of defining and naming the themes. The scope captured by each theme was thus defined in terms of this study's research aim and objectives. This section

discusses the key insights related to the respective themes and includes relevant data extracts to substantiate each theme.

5.2.5.1 Challenges of being a psychologist.

The first theme relates to the challenges of being in the psychology profession. These challenges centre around the subthemes of occupational challenges, client-related challenges, and the negative effects experienced from practising as a psychologist.

The subtheme of occupational challenges incorporates the demands of the work setting and regulatory issues. Working in a private practice or in public service, from home, in a shared practice, in a psychiatric facility, or in a combination of these, impacts the experience of the psychologist. Both public sector and private practice hold the challenge of long working hours with demand that is subject to seasonal fluctuations. To an extent, the seasonal pattern in private practice is influenced by the availability of medical scheme benefits. In the public sector, the increase in demand seems to relate to the warmer seasons and periods following school holidays and public holidays. Administrative tasks inflate the burden shouldered by psychologists. The management and maintenance of a practice contribute significantly to the responsibilities of participants in private practice.

The regulatory issues that psychologists face include dealing with medical aids, the envisaged National Health Insurance, the Board of Psychology of the Health Professions Council of South Africa (HPCSA), and governmental oversight. The national lockdown in response to the COVID-19 pandemic is an example of how governmental oversight impacts psychologists' opportunity to practice. Table 5.3 lists illustrative extracts pertinent to the subtheme of occupational challenges.

Table 5. 3
Theme 1: Challenges of being a psychologist (occupational challenges)

Code	Person	Data extract
Work setting demands	Edith	*"The other aspects of running a practice, not just the patients, [are] also a big contributor to burnout. … Instead of maybe spending a weekend doing self-care, you're spending the weekend doing admin, writing letters, you know, all that other kind of stuff."*
		"This year in February, March, late January I was probably seeing like, ja, maybe [in] excess of 30 patients a week. … It is just hectic."
	Estell	*"We get the, the problems with substances where um, there again it's the distress associated with substances that brings parents to the clinic um, in the warmer months."*
	Lilith	*"So generally what you're looking at – and it's really not just me, it's people in practice, this is what we look at – you're starting at six, half past six in the morning. You are very lucky to walk out seven or later. … So you take in appointments that you think 'Oh sh*t, how am I going to fit this person in?' But you fit them in, because you have to."*
		"July is quiet. I've been in the game long enough, I know July. But those who haven't, haven't made financial provision, they're anxious."
	Lionel	*"The sensation that I get now is actually a vibrancy on the one side, because I love what I do, but on the other hand I think there's definitely a realisation that I can't continue like this. I have to slow down."*
	Michael	*"For one to be a successful psychologist – and specifically in private practice I'm talking now – um, you've gotta be a good business person on top of it. … I have a very good office manager that does that [administration] on my behalf, which takes a lot of load from my shoulders."*
	Mitch	*"We're also dealing then with social stresses of not having money, not having food, not [being] able to do their piece jobs. … A lot of our very traumatic cases come through Christmas, because people are home, … people are drinking more."*
Regulatory issues	Edith	*"[There] is this massive scope of practice thing going on between, you know, the medical aids and the HPCSA and all sorts of organisations."*
	Estell	*"I also in my private practice see some of the effects of um, managing without the, the full extent of income that I usually am um, accustomed to."*
		"With this lockdown we've had many presentations to the clinic where people come and they ask for… um, they need the crisis intervention right now. … The people want to be admitted to escape their situation."
	Lilith	*"But those things are demanding. When we went through the whole drama that never ended on scope of practice, the amount of anxiety that caused in practitioners – and that worsens this sort of effect – because it's constant with colleagues saying 'I know I can do this, but am I allowed to do this?' And other cr*p from the Professional Board of Psychology, who are completely and utterly useless."*
	Michael	*"But can you imagine their [psychologists without adequate financial resources] stress levels now during these times [of lockdown] when there's no income or very low income? Because a lot of people don't feel comfortable doing Skype therapy or Zoom therapies."*
	Mitch	*"So in a certain sense, um… my work has become more… different in the sense of I'm also seeing other categories now. But ironically it is even now more stressful because we're dealing with the whole COVID-19 situation."*

The next subtheme is client-related challenges, which involve type of clients and the psychologist's responsibility towards clients. The type of clients impacted how the participants experienced the challenges of their work. Aspects included the presenting problems and socio-economic environment of clients. Whether sessions were, for example, with individuals or couples, impoverished, traumatised or boring clients, affected the experience of participants. Additional stress is caused by specific clients who harass the psychologist either personally or legally. Participants acknowledged that they bear a deep responsibility towards their clients. This feeling of responsibility resulted in clients' needs often taking precedence over those of their therapists. Table 5.4 lists extracts to illustrate the subthemes of client-related challenges.

Table 5. 4
Theme 1: Challenges of being a psychologist (client-related challenges)

Code	Person	Data extract
Type of clients	Edith	*"It's some of the most exhausting and draining – couples counselling – that one can do, instead of maybe just a one on one."*
	Estell	*"I've had instances where my patient pulled out a knife in my office to, um, to self-mutilate …. I've had someone take an overdose in my office. I've been bitten by a child in the middle of a temper tantrum."*
	Lilith	*"But your chronic trauma, your childhood trauma, early traumas, that's a completely different ballgame …"*
		"I have often, even when I would say I was not burnt out particularly, I don't do well with clients that are boring."
	Michael	*"I've worked with borderlines who don't think twice to take you to the Health Professions Council and make some frivolous vexatious claim. … I see a lot of childhood sexual abuse cases, and um, the like, so a lot of PTSD."*
	Mitch	*"There, there is a side of me not wanting to work in trauma for the next 10 years."*
Responsibility towards clients	Edith	*"So that kind of like deep sense of responsibility we often feel towards our clients, you know, is a contributor to that emotional exhaustion and eventually burnout, because people are so needy, they are so dependent on you, and you feel… so responsible that, you know, you kind of put your own self-care secondary."*
	Estell	*"And sometimes I'm, I'm exhausted and I don't necessarily have the capacity to be there for my loved ones in the same way that I'm there for my patients."*
	Michael	*"But still the work is tiring and it is stressful and you work with a huge amount of um… responsibility. I mean people really wanna commit suicide, people are really at the end of their tether, people suffer with mental illness."*
	Mitch	*"Though there is still me, but there is myself being the therapist. And when I'm then with a client, … in that time it is about the client. So in a way I, I put myself aside then."*

Finally, the challenges of being a psychologist would be incomplete without an exploration of the subtheme of the negative effects related to this work. The participants' accounts of negative effects included physiological and psychological aspects. The physiological expression of these effects involved elevated stress arousal, physical exhaustion, insomnia, and falling ill. Therapists may feel flooded, feel an emotional disconnect with clients and loved ones, experience intrusive images from sessions, or feel bored. It is imperative that psychologists notice these negative effects so that they can take action – or reduce activity – to sufficiently recover. Table 5.5 lists illustrative extracts applicable to the subtheme of negative experiences.

Table 5. 5
Theme 1: Challenges of being a psychologist (negative effects)

Code	Person	Data extract
Experience of negative effects	Edith	*"I start to feel an extreme sense of, like this emotional exhaustion, like, like when you're sitting with that client and you feel very disconnected from them, and you just inside just feel absolutely almost numb. … That connection is lost. And there is no desire to connect either."*
		"You sit there and you're listening to people and you kind of have the sense of 'I actually don't care, just shush and go away.' You know, obviously now that is at the end of the year, this is where you get into that extreme point …"
	Estell	*"And to some degree it [harassment by a patient] made me rethink whether I want to be in this job, whether I'm willing to deal with someone that is really that sick, um… Yes, someone else's sickness can to some degree also be contagious, and make me sick as well."*
		"But when I'm burnt out, or when I'm – let's say – not all that present, when I'm tired also, it's like I'm, I'm present in body but not in mind so much."
		"I've noticed this pattern where um, there are times that I feel completely flooded and I'm, I'm just going through the motions: get up, work, eat, go to sleep, repeat, repeat, repeat. And then there comes a time that I feel that if I'm gonna see one more patient, I'm gonna be a patient myself."
	Lilith	*"When you've worked routinely with severe trauma, you yourself undergo changes. You are on, let's – for want of a better term for the moment – say that you have heightened adrenalin levels. You get used to that."*
		"Say I saw someone who did something or other horrible, okay, um… and I was stupid enough to go to Pilates, that would be the height of stupidity, because there's no way in that instance, you'll remove the images, you can't."
	Mitch	*"Your whole… outlook on life changes. You become very different, um… in how you see life. Life becomes much more a frightening world out there."*
		"Especially when I start having um, sleepless nights, insomnia, this kind of one-two-three-awake every night. Then I know I'm in trouble. And, and just also when I start withdrawing from others. So I become a bit more irritable with people."

5.2.5.2 Rewards of being a psychologist.

The second theme represents the positive aspects that participants reported from practising as psychologists. Perceived positive therapy outcomes contributed to their feeling of having a beneficial impact and that their work was significant. In addition, the specific therapeutic modalities employed by participants may also have influenced their experience of these outcomes. Their individual attitudes towards the profession seemed to relate not only to identifying with the profession from a personality level but also to gaining variety, meaning, and purpose from the work. Table 5.6 displays data extracts to demonstrate this theme.

Table 5. 6
Theme 2: Rewards of being a psychologist

Code	Person	Data extract
Therapy outcomes	Edith	*"When you do get that feedback, you do tend to hold onto it … realising that, you know, what I am putting into this, the emotional energy, the compassion, the... it's good enough that, you know, you are making some kind of impact and then there is that sense of like, okay, a job well done."*
	Estell	*"I think that when I see my patients grow – and I commend them for that – it, it gives them a lot of benefit to, to have someone noticing changes. But also I have a sense of satisfaction when I'm trying to teach someone something, and they take it to heart and they apply it."*
	Lilith	*"Working the field of trauma, people get better most of the time. But especially acute trauma, it's very quick, generally easy to work with, um, get good results, um, people recover quickly … I know what to do, I know the steps, I've been down that road a thousand times, …"*
	Lionel	*"I do at least half of my sessions in practice, I do hypnosis. If it wasn't for that, I don't think I would have been able to do so many sessions a day and in a week. … So yes, in my own practice I see the results of it. The nice thing about it also, is that most of your clients and patients that you see, you don't have so many sessions."*
		"I think this is why most of the people I see are self-referred, you know, by word of mouth, and most definitely there is a change, and what I like about it is that it's not a change with effort …"
	Michael	*"The positive aspects include the, the transformation I see with my patients on a very regular basis: suicidal people who rediscover their um, love for life. I see really astounding results in my work. That gives me a lot of pleasure."*
	Mitch	*"I think another positive is not only my own fulfilment, but also knowing that my, my life and my work is meaningful to others."*
		"And then starting to see the resilience of people that's going through the whole trauma, the whole… becoming a survivor – so from victim to survivor – started giving me more hope. Um, and seeing what people were able to do. … They have learnt skills, they've learnt ways of dealing with the horror and with the trauma. And, and they can deal with that in life."

Code	Person	Data extract
Attitude towards job	Edith	*"If you have a sense of competency in what you're doing, um, you know, because it just gives you a sense of that efficacy and that sense of 'What I'm doing is good enough,' …"*
	Estell	*"I find it very rewarding and um, this is a very self-serving aspect, but I'm a very curious person and it just brings some diversity to my life. And um, I often come home at night feeling very thankful for how boring my life is, and how, or how uncomplicated it is, after hearing the things that I hear in my daily job. So yes, I find my job interesting and I feel that it, it builds me, and it contributes to my life in many ways."*
	Lilith	*"At the moment I want them better and out of my office as quickly as possible."*
	Lionel	*"And it's not just a job, I think self-hypnosis or mindfulness, meditation is a lifestyle, it's not a tool."*
		"I think my personality type automatically steered me towards helping people."
		"And this is exactly why I see myself working till the day my head just drops, you know (laughs), I love what I do."
	Michael	*"I love what I do, because every patient is different, no single one is the same. … So I, you know, so many aspects of my soul is being fed. I get a lot of meaning from it, a lot of purpose from it. … If I don't do this, I don't know what I'll be doing, 'cause I really enjoy doing this. … And I'm hoping to be an 80-year-old psychologist one day."*
	Mitch	*"I already know that [practising as a psychologist] is what I am going to do. Um… it, it is something that… it fits me. It is for me a way of life. And it, it's not bad. It's, it's not great either. It is just 'This is what it is.' And I, and I can't see myself in the next couple of years doing something radically different."*

From Table 5.6, it is evident that the three participants who had low burnout scores – Estell, Lionel and Michael – expressed particularly enthusiastic attitudes towards their work as psychologists.

5.2.5.3 Self-care facets.

This theme explores how participants apply self-care. The subthemes include work-related self-care and personal self-care.

Managing the work setting featured as an important aspect of work-related self-care. Limiting bookings and working hours and determining the sequence and types of clients were aspects that contributed towards this category of self-care. Employing someone to assist with administrative aspects was a consideration in private practice.

Undergoing additional specialised training was identified as a prominent contributor to professional self-care. Participants stated that the skills acquired through further training

reduced the effort on their part when providing therapy. In many training courses, psychologists simultaneously undergo a level of therapy themselves by having to practice the modalities with other course attendees, which advances their own psychological healing.

Input from colleagues played an important role in work-related self-care and included supervision, own therapy, informal discussions, and support groups. Table 5.7 lists data extracts related to work-related self-care.

Table 5. 7
Theme 3: Self-care facets (work-related self-care)

Code	Person	Data extract
Managing work setting	Edith	*"I got to a point where I was booking lunch hours, because otherwise I was seeing eight patients straight."*
		"You often have people, requesting 'Can you see me after hours, can you see me after this, after …' and I've learnt to say no, because then I'm only getting home at seven o'clock, eight o'clock and then, you know, it starts again."
		"And in managing your day and your boundaries is even, you know, simple things like that 'Okay, I only see one couple a day.'"
	Estell	*"I try my best to, to limit the number of patients I see in a day. … I feel that if I'm not okay, I will not be able to help someone else be okay. And if I'm so exhausted, I won't have the full capacity to, to give my best service to the person sitting in front of me."*
		"I make my own bookings and um, I am also aware that um, certain cases need to be scheduled around certain times of the day. If it's a, a difficult case I will place them before lunch, so that I have a break after that. Um, or at the end of the day when I get to leave the context and I won't have to deal with other people altogether. And then I sometimes also try mix up more um… enjoyable, easier cases with the more difficult cases so [that] the one person's effect neutralises that of the other."
	Lilith	*"At the moment I'm trying not to get involved in too much chronic trauma."*
		"I do my own bookings. So even when I've had a full time receptionist, I've made my own appointments. I will not put certain, people who are a certain way along the process next to each other, it's too demanding. So I would intersperse them with other people that I know: this is a follow-up session, or it's the intake, or… um, I know we're gonna do this, um, this is a 'bring things together', it's not going to be an issue, it's not emotionally demanding."
	Lionel	*"This is what I'm already busy planning during the last two years, to not stop working, but to work less and do more of the work that I really enjoy, the type of cases, you know, and topics."*
	Michael	*"I work from home. I have arranged my life that um… I look out on my garden, I've got a beautiful garden outside."*
		"I have a very good office manager that does that [administration] on my behalf, which takes a lot of load from my shoulders."
		"And I'm hoping to be an 80-year-old psychologist one day. I might not see nine patients a day, I'll see four or five perhaps (laughs)."

Code	Person	Data extract
Additional training	Edith	*"So when, you know, I went for the training, it literally changed my life. You know, where I had structure, I had guidance, I knew what I was doing, I feel confident in what I'm doing."*
		"Sometimes we do feel a bit like we're feeling around in the dark, um, because we don't always have training, especially in those starting out. Master's is an overview."
	Estell	*"My private practice I've always treated more for um, let's say spending money. I'm paying for more expensive courses that I wouldn't necessarily be able to pay for just based on my state salary."*
	Lionel	*"During your training – the [hypnosis] training I did – seventy percent of the time you actually have to work with your own problems or issues, which I did."*
	Michael	*"When they trained us in hypnotherapy, we had to do a lot of our own work. So a lot of my healing I've done it 'coincidentally', by doing the trainings."*
		"So it [training abroad]is very expensive, but… do I regret that, whatever that amount was, one moment? No, I don't. Because I'm using it, because I'm seeing the results, because I use that same stuff I've learned for my patients."
		"So for me um, emotional, um, personal transformation and educational learning new stuff often goes hand in hand. Coincidentally, it's not even planned that way."
	Mitch	*"I do a lot of training that I really enjoy. Um, and I work in complete[ly] different fields um, than the trauma. I find myself doing something that is more creative um, intellectually. And ja, going to do training and engage with people in other fields, um to be very positive."*
Input from colleagues	Edith	*"The one colleague, she was my supervisor during my internship, so she trained me, we have a very good relationship. So, because I mean there's a shared sense of confidentiality, all of that, I mean, you can, we can discuss cases with each other, you know, and provide support as needed. Actually I must say the whole [shared] practice is actually, there's a good sense of rapport amongst everyone."*
	Estell	*"I have regular um, colleague contact, which I think is really a buffer um in terms of the debriefing aspects. Someone to do some reality testing with at the end of the day where we sit."*
		"I'm in supervision to help me when there are more um, more difficult cases or things that I struggle with. And I think to some de… to a large degree, that is also buffering me against burnout. I think that's one of the things that's really helping me a lot. This fact, the sense of professional and collegial validation for, for my experiences."
	Lilith	*"I don't know of anyone who manages anything [in terms of self-care] in the beginning of the year. About the best we will do, probably, someone contacted me earlier today and said to me 'Can we have a supervision session online tomorrow?' 'Yes.' Um, because that's about the best you'll manage."*
	Lionel	*"To be able to receive as well, and not just give, is vital. Which I've done during my training, but also at, you know, after certain traumatic experiences. I actually went to colleagues that obviously have the same approach that I do, and I've experienced that first-hand, you know, the effect of it."*
	Michael	*"I've done a fair amount of going to see psychologists."*
	Mitch	*"And then also I do still attend, um therapy. I've done it over all the years that I've been working in this place, and I still do that."*

The particulars of personal self-care may vary depending on an individual's subjective preferences, but one central aspect is self-compassion. For participants, self-compassion meant being willing to accept being human, at times putting their own needs first, or giving up appearing strong and competent (both at home and with clients).

Another prominent self-care need participants identified was taking time out from work, whether as short breaks between sessions, evenings at home, weekends away, or longer holidays. Being in the "peopling" business, participants considered time for solitude as an essential part of personal self-care. Table 5.8 lists illustrative extracts pertinent to the subtheme of personal self-care.

Table 5. 8
Theme 3: Self-care facets (personal self-care)

Code	Person	Data extract
Self-compassion	Edith	*"But the more you start to feel that emotional drain and exhaustion, the more you realise 'Hey, you know what, I actually come first.'"*
	Estell	*"I had to give up on this notion of being the perfect accomplished housewife who could cook meals and had a clean house, and all that. So this job would be my third job then, 'cause I already had two jobs."*
	Lionel	*"When you deal with trauma in your own life properly, not just talking about it, but for me hypnosis is actually accessing it. … When you do that, you are actually allowing yourself to be human. And when you have compassion for yourself, accepting yourself irrespective of all of your hiccups and hang-ups and whatever, then you have more compassion for other people."*
		"And when you deal with that [own trauma], if you have compassion for yourself, if you take time out for yourself, you reflect, you read, you talk to people, and… if you do that, you can actually open up to other people as well. And you create a space for them because you create a space for yourself."
	Michael	*"I think being a joyous psychologist and a joyous human being has helped me tremendously, uh, to, to have a much softer approach towards my life."*
	Mitch	*"I liked to have this idea of being this strong person that can cope. And, and coming to a point of saying 'You know, it's okay. I, I don't have to be strong. I don't have to cope'. I don't have to be this image of this strong parent – for example – for my kids."*
		"But reflecting on it: being more compassionate with self, and allowing to just go and sleep, or just lie down and have a good cry, that that is also an act of self-care, although it looks very different than I would have structured it originally."
		"So I, I don't need to be this… ja, strong, 'in control' person anymore. I, I can just be me."

Code	Person	Data extract
Taking time out	Edith	*"So my self-care has to be, like, isolation, spending time by myself to recharge, you know, no demands or pressures on me. … I need to have that kind of bubble-time where I have no people interaction."*
		"And I found now that that 'just stopping' just for, even just a few minutes, it makes a difference. There's so much going on around you and inside you. To actually just almost disconnect from that for… a couple of moments, and just gather yourself, it kind of helps you get through, let's say the next hour."
	Estell	*"I do need alone time and I do need time away from people and not to speak to people. Um, but I also enjoy socialising, um it's just that I need to, to practise – um let's call it efficient dosage – not too much isolation, but not too much socialisation."*
		"My husband and I take, try to take regular breaks away from home. … We try to um, go out on a little um, weekend away for, to just explore things."
		"And then two or three times a year we try to go for a bit of a longer break, just to really get away from the, the everyday."
	Lilith	*"I paint when I can, I used to try and do it Sunday evenings as a transition, but I simply don't manage to fit it in now."*
	Lionel	*"Coming back to hypnosis again: um, when one does hypnosis or self-reflection you're actually taking time for yourself, you can't give what you don't receive."*
		"I think, um, the, the challenge is actually to, um, take time out on your own."
		"Fortunately our children have left the home now, and they're out, but the wonderful thing for me in my marriage is that my wife and I can give each other that space."
	Michael	*"When comes December, I normally close between about the fifteenth of December till the first week of January. It's also nice to go on holiday and to do something else for that time."*
	Mitch	*"I have found literally playing games being very good. So Sudokus, stuff that I can organise and categorise, and put into place. Um, there, there's something weird about that. And as I do that I have time to think and process. So it's in a certain way (laughs) putting the logical side doing something and, and dealing with the emotions."*
		"I found being with my children being exceptionally good for me. Because when you're with your kids, that can also draw my attention away from the trauma. And I can be in the moment with them. So I've found that being exceptionally therapeutic."
		"Sometimes I would just withdraw and sleep, and there fortunately my partner understands."

5.2.6 Phase 6: The final report.

The final phase of thematic analysis involves writing a report based on the themes and illustrating the narrative with data extracts to substantiate each of the themes (Braun &

Clarke, 2006). In keeping with the explanatory purpose of the qualitative phase, this report of the thematic analysis is included with the discussion of results in Chapter 6.

5.3 Conclusion

This chapter outlines the phases used to guide the thematic analysis of the qualitative data collected. Using Braun and Clarke's (2006) approach to thematic analysis, the three themes identified were: challenges of being a psychologist, rewards of being a psychologist, and self-care facets.

The final chapter discusses the quantitative results and utilises the themes identified from the qualitative data to produce an integrated interpretation. This is followed by limitations of the study, suggestions for the training and support of psychologists, and recommended future research.

CHAPTER 6: DISCUSSION, LIMITATIONS OF THE STUDY, RECOMMENDATIONS FOR FUTURE RESEARCH AND CONCLUSION

6.1 Introduction

This chapter discusses the results of the study with regard to its aim and objectives − it utilises the qualitative data to enhance the interpretation of the quantitative data. This chapter also points out the study's limitations and makes recommendations for future research. As intended, suggestions related to the training and support of psychologists are listed and the conclusion completes the chapter.

6.2 Quantitative Results

The quantitative results are discussed according to each assessment measure applied. The ProQOL-21 results are followed by those of the CBI and then the SCAP. The discussion on the prevalence of compassion satisfaction, compassion fatigue, burnout, and self-care is augmented by the relationships explored among assessed constructs and biographic variables.

6.2.1 Compassion satisfaction and compassion fatigue.

Considering the prevalence of low compassion satisfaction among participants (as depicted in Figure 4.1), there were visible differences between the late career group (14.3%) and the early (28.2%) and mid career (25.0%) groups. The relationship between years of practice and compassion satisfaction was evident in a significant small positive correlation obtained ($r = .248$, $p < .01$) (see Table 4.8). This relationship was confirmed by a comparison of the career groups using a MANOVA, which indicated a significant difference in compassion satisfaction between the early and late career groups (see Table 4.13). The higher levels of compassion satisfaction for the late career group lends support to the findings of other researchers. In a study investigating professional quality of life among trauma specialists (including clinical psychologists and clinical social workers) ($n = 532$), Craig and

Sprang (2010) found that more years of experience predicted higher levels of compassion satisfaction. Laverdière et al. (2019) reported a positive association between years of experience and compassion satisfaction ($r = .28$, $p < .001$) among Canadian psychotherapists ($n = 240$). From their study on the quality of life of 98 trauma counsellors, McKim and Smith-Adcock (2014) also found a positive correlation between years of clinical experience and compassion satisfaction. Wagaman et al. (2015) likewise reported higher levels of compassion satisfaction in social workers ($n = 173$) with more years of experience.

No significant relationships were found between compassion satisfaction and either the number of weekly therapy sessions or number of weekly trauma therapy sessions (see Table 4.8). This then does not support Killian's (2008) finding that more hours of clinical contact were significantly inversely correlated with compassion satisfaction in a study with 104 specialist trauma therapists. Killian's (2008) study was conducted on therapists working primarily with sexually abused children, which implies that almost all of their clients would have been highly traumatised. This may have contributed to the inverse association between contact hours and compassion satisfaction (Killian K. D., 2008).

Considering the normed scores for compassion fatigue (see Table 4.2), there were visible differences in compassion fatigue between the late career group and the early and mid career groups. These apparent differences are also perceptible in Figure 4.2, which depicts the prevalence of high compassion fatigue in the late career group (13.0%) compared to the early (29.4%) and mid career (28.9%) groups. A significant, albeit small, negative relationship between compassion fatigue and years of experience ($r = -.178$, $p < .01$) is evident in Table 4.8. The relationship was confirmed by a comparison of the career groups using a MANOVA, which showed significant differences in compassion fatigue between the late career group and the early and mid career groups (see Table 4.13). This corroborates the finding of Sprang et al. (2007) that among mental health providers ($n = 1,121$) less clinical experience predicted

higher levels of compassion fatigue. In another study with mental health counsellors (n = 213), Thompson et al. (2014) also reported a negative association between years of experience and compassion fatigue.

In light of the relationship found between years of experience and compassion fatigue, it is argued that late career psychologists tend to enjoy more compassion satisfaction and suffer less compassion fatigue than their less experienced colleagues and that compassion satisfaction may contribute to reducing compassion fatigue. This argument is further explored in the integration of the quantitative and qualitative data (see 6.4).

A significant positive relationship was found between the number of trauma therapy sessions per week and compassion fatigue (r = .293, p < .01) (see Table 4.8). This positive relationship supports the finding of Sprang et al. (2007) and Craig and Sprang (2010) that the percentage of clients with PTSD seen by mental health providers and trauma therapists respectively positively predicted compassion fatigue. The amount of secondary trauma exposure was also a significant predictor in a study with trauma counsellors (McKim & Smith-Adcock, 2014). Laverdière et al. (2019) similarly reported a positive association between working with trauma victims and secondary traumatic stress.

Compassion satisfaction exhibited significant negative relationships with compassion fatigue (r = -.401, p < .01), personal burnout (r = -.421, p < .01), work-related burnout (r = -.534, p < .01), and client-related burnout (r = -.600, p < .01) (see Table 4.8). The negative relationship between compassion satisfaction and compassion fatigue corresponds with previous researchers' findings, such as Rossi et al. (2012) who conducted a study with Italian community-based mental health staff (n = 260) and reported negative correlations between compassion satisfaction and compassion fatigue and between compassion satisfaction and burnout. Thomas (2013) likewise reported a moderate negative association between

compassion satisfaction and compassion fatigue and a strong negative association between compassion satisfaction and burnout among clinical social workers (n = 171).

Conversely, a significant strong positive relationship was found between compassion fatigue and personal burnout (r = .730, p < .01), work-related burnout (r = .744, p < .01), and client-related burnout (r = .691, p < .01), respectively (see Table 4.8). The positive relationship between compassion fatigue and burnout was anticipated, as it featured in the literature for community-based mental health staff (n = 260) (Rossi et al., 2012), clinical social workers (n = 171) (Thomas, 2013), and mental health counsellors (n = 213) (Thompson et al., 2014). The observed strong association between compassion fatigue and the burnout subscales in the present study is arguably an indication of a possible directional link between these constructs.

Significant small to moderate positive relationships were found between compassion satisfaction and all the self-care subscales, with cognitive awareness (r = .398, p < .01) and life balance (r = .349, p < .01) showing the strongest correlations (see Table 4.8). The latter result validates the positive relationship between compassion satisfaction and self-care reported by Salloum et al. (2015) in a study that examined the role of self-care in relation to the professional quality of life of child welfare workers (n = 104). In a study with mental health workers (n = 90) who worked with adolescent sex offenders, self-care and compassion satisfaction also showed a strong positive relationship (Kraus, 2005). Radey and Figley (2007) asserted that self-care is one of the aspects that facilitates compassion satisfaction by promoting a higher ratio of positivity to negativity.

Among the SCAP subscales, life balance (r = -.397, p < .01), daily balance (r = -.378, p < .01), cognitive awareness (r = -.340, p < .01), and professional support (r = -.150, p < .01) showed negative correlations with compassion fatigue (see Table 4.8). This supports the argument of Ludick and Figley (2017) that self-care may promote resilience against

compassion fatigue. However, no relationship between compassion fatigue and self-care was found by Kraus (2005) among mental health workers (n = 90) who worked with adolescent sex offenders or by Salloum et al. (2015) among child welfare workers (n = 104). Both these studies were conducted with samples from populations who were regularly exposed to secondary trauma in their work. This elevated the potential for compassion fatigue and may account for the lack of association between self-care and compassion fatigue.

6.2.2 Burnout.

The participants reported elevated personal burnout and low client-related burnout overall and per career group. Fifty-seven (23.9%) participants met the criteria (CBI score ≥ 50) for overall burnout, 101 (42.4%) for personal burnout, 70 (29.4%) for work-related burnout, and 42 (17.6%) for client-related burnout (see Table 4.6 and Figure 4.3). These prevalence percentages are comparable to those found among American graduate-level and professional clinicians (n = 207) (Warlick, Van Gorp, Farmer, Patterson, & Armstrong, 2020). The percentages found in this study are, however, higher than those reported (overall burnout 14.4%, personal burnout 35.3%, work-related burnout 20.4%, and client-related burnout 12.6%) in a study correlating burnout with work setting and self-care among 167 Australian psychologists (Di Benedetto & Swadling, 2014). The difference may be explained by a more challenging life and work context of the participants in the current study. Both the latter study and the current results indicated the prevalence of personal burnout as the highest and client-related burnout as the lowest.

The correlations between the CBI subscales and both compassion satisfaction and compassion fatigue are discussed in 6.2.1. In terms of biographical variables, years of practice showed significant small negative associations with personal burnout (r = -.187, p < .01), work-related burnout (r = -.235, p < .01), and client-related burnout (r = -.203, p < .01) (see Table 4.8). This supports the finding of Wagaman et al. (2015) that associated

more years of practice among social workers (n = 173) with lower burnout levels. Similarly, a study about burnout among Australian psychologists (n = 167), found more years of experience to have a low negative correlation with overall burnout (Di Benedetto & Swadling, 2014). From their systematic review of studies about personal risk factors associated with burnout, Simionato and Simpson (2018) also reported that less work experience was a risk factor for moderate-high burnout levels.

Therapy sessions per week showed significant small positive correlations with personal burnout (r = .232, p < .01), work-related burnout (r = .287, p < .01), and client-related burnout (r = .173, p < .01) (see Table 4.8). In addition, trauma therapy sessions per week also showed significant small positive correlations with personal burnout (r = .281, p < .01), work-related burnout (r = .285, p < .01), and client-related burnout (r = .198, p < .01) (see Table 4.8). The latter result supports the finding of a study among trauma therapists (n = 532) that the percentage of PTSD clients in caseload positively predicted burnout. (Craig & Sprang, 2010). Laverdière et al. (2019) also reported a small positive association between caseload volume and burnout in their study on professional quality of life among Canadian psychotherapists (n = 240).

All the burnout subscales demonstrated significant small to large inverse correlations with all the self-care subscales (from r = -.171 to r = -.528, p < .01) (see Table 4.8). Among these, the two strongest relationships were between daily balance and personal burnout (r = -.521, p < .01) and daily balance and work-related burnout (r = -.528, p < .01). This result supports the reported inverse relationship of self-care to burnout found in child welfare workers (n = 104) (Salloum et al., 2015). However, Kraus (2005) found that self-care did not strongly influence burnout among mental health workers (n = 90) who worked with adolescent sex offenders − this is likely related to the highly distressing nature of their work.

The results from the MANOVA of the CBI subscale data show significant differences between the early and late career groups on personal burnout, work-related burnout and client-related burnout, but no significant differences between the early and mid career group scores (see Table 4.17). The only significant differences between the mid and late career groups were for personal burnout and work-related burnout scores. Di Benedetto and Swadling (2014) offered two possible explanations for their similar result of lower levels of burnout among psychologists with more years of practice: either those who are more susceptible to burnout leave the profession at an earlier stage or psychologists develop resilience against burnout over a longer career span. Simionato and Simpson (2018) as well as McCormack, MacIntyre, O'Shea, Herring, and Campbell (2018) reached the same conclusion in their systematic reviews of the prevalence and causes of burnout among psychologists. Considering how challenging it is to be accepted into a South African master's programme and how demanding the training is, the researcher considers it likely that the majority of South African psychologists remain in the profession. This would support the notion that psychologists develop ways to cope with occupational demands over time. Furthermore, the lower burnout of the late career group may partially be due to reduced family obligations when children have left the home (Dorociak et al., 2017b) and to psychologists experiencing a financially more stable stage of their careers that lessens their stress load.

6.2.3 Self-care.

With possible scores ranging from 1 (never) to 7 (almost always) on the SCAP subscales (see 3.4.1.4), the mean scores obtained were 4.96 for both professional support and professional development, 5.71 for life balance, 5.86 for cognitive awareness, and 4.88 for daily balance (see Table 4.7). Life balance and cognitive awareness can be inferred to be the

self-care dimensions that participants applied most often and daily balance the least frequently.

The number of therapy sessions per week showed inverse correlations with daily balance (r = -.454, p < .01) and life balance (r = -.139). Trauma therapy sessions per week also resulted in similar inverse correlations with daily balance (r = -.357, p < .01) and life balance (r = -.128, p < .01) (see Table 4.8). A higher caseload conceivably leaves less time for self-care activities, as indicated by the moderate negative association with daily balance and small negative association with life balance. In a study that examined self-care practices among child welfare workers, Miller, Donohue-Dioh, Niu, Grise-Owens, and Poklembova (2019) likewise found that self-care practices were negatively associated with number of hours worked per week. The relationships of the self-care subscales with compassion satisfaction, compassion fatigue, and burnout are discussed in 6.2.1 and 6.2.2.

The correlational analysis yielded no significant correlations between career stage and any of the self-care subscales (see Table 4.9). This was confirmed by a non-significant result obtained in the subsequent MANOVA (see Table 4.18). Self-care scores therefore do not differ significantly by career stage in the current sample. Dorociak et al. (2017b) found inconsistent results in regarding career stage and self-care frequency in two different samples (n = 333 and n = 277). In their research, late career psychologists from the first sample reported more frequent self-care behaviours compared to early career psychologists, while in the second sample the early career group exhibited more frequent daily balance practices. Their recommendation for further research regarding aspects affecting self-care across career stages (Dorociak et al., 2017b) is therefore supported.

6.2.4 Predicting Compassion Fatigue.

In view of the relationships among the variables described thus far, two standard multiple regressions were conducted to determine whether compassion fatigue can be

predicted by compassion satisfaction, burnout, self-care, number of trauma therapy sessions per week, and career stage. The CBI subscales were included as three separate predictor variables in the first multiple regression analysis (see 4.5.1). The model evaluation confirmed that 62.9% of the variance in compassion fatigue was attributed to the independent variables (see Table 4.19). The strongest significant predictor of compassion fatigue was personal burnout (beta = .286, p = .002), jointly followed by work-related burnout (beta = .273, p = .012) and client-related burnout (beta = .273, p < .001). Psychologists who report high personal burnout, work-related burnout, and client-related burnout are therefore more likely to be at risk for compassion fatigue. The only other significant predictors were professional development (beta = .159, p = .014) and life balance (beta = -.122, p = .039). The positive coefficient of professional development may indicate that those therapists at risk of compassion fatigue attempt to counteract this by paying more attention to professional development activities. Where life balance measures the frequency of social connection, the negative coefficient implies that when psychologists less frequently seek out supportive social connections, their risk for compassion fatigue may be higher.

The second standard multiple regression was done with the same predictor variables, except that the burnout subscales were combined into a single burnout score obtained from the average of the respective subscale scores. In this model, the independent variables accounted for 62.9% of the variance in compassion fatigue. The strongest predictor of compassion fatigue was the combined burnout score (beta = .777, p < .001), followed by professional development (beta = .159, p = .013) and life balance (beta = -.122, p = .036). The overall burnout score therefore strongly predicts compassion fatigue, which implies that psychologists displaying high burnout are more at risk of suffering from compassion fatigue. Previous studies have provided evidence for the positive association between burnout and compassion fatigue (e.g., Rossi et al., 2012; Thomas, 2013; Thompson et al., 2014). Shoji et

al. (2015) found that among human services professionals exposed to indirect trauma higher levels of job burnout resulted in higher secondary traumatic stress measured six months later − but not vice versa. The result of Shoji et al.'s (2015) study may hint at a causal direction between burnout and compassion fatigue.

6.3 Qualitative Results

The qualitative phase of this study aimed to explore the subjective experiences of practicing psychologists from different career stages regarding compassion satisfaction, compassion fatigue, burnout, and self-care. The data collection for the qualitative phase involved online interviews that were recorded and transcribed. The six interviews included two from each career stage. As described in 3.3.2, the researcher selected one participant with high burnout and one with low burnout from each career stage group.

Thematic analysis (see 3.6.2) produced three main themes and six subthemes. The main themes are the challenges of being a psychologist, the rewards of being a psychologist, and self-care facets. In this section, each theme is discussed employing the assigned pseudonyms to reference interview extracts.

6.3.1 Challenges of being a psychologist.

The first main theme is the challenges of being a psychologist (see 5.2.5.1). This theme includes three subthemes: occupational challenges, client-related challenges, and negative effects.

6.3.1.1 Occupational challenges.

In terms of occupational challenges (see Table 5.3), participants described how each of their work settings contribute to challenges they experience. Some participants mentioned that the challenge of running a private practice included the management of many aspects apart from client contact that required additional time and effort. As Edith explained,

"Instead of maybe spending a weekend doing self-care, you're spending the weekend doing admin, writing letters, you know, all that other kind of stuff." Delegating some of these aspects worked well for Michael, *"I have a very good office manager that does that [administration] on my behalf, which takes a lot of load from my shoulders."*

Maintaining a private practice financially also featured in participants' challenges. This included accommodating referrals from psychiatrists and doctors on short notice; as Lilith accepted, *"... but you fit them in, because you have to."* The training of psychologists does not include business skills, which may add to the strain experienced in private practice. Michael maintained that *"... for one to be a successful psychologist – and specifically in private practice I'm talking now – um, you've gotta be a good business person on top of it."*

Those participants working primarily in public health are confronted with the day-to-day realities of the community served by each clinic. Social stresses such as poverty, unemployment, substance abuse, and physical abuse are common in these settings. As Mitch observed, *"... you become aware of the horrors of what's out there in the community."* The pressure of having to buy stationery required by schools brought the financial dilemmas faced by the community into Estell's office, *"... buying a pencil and three pens is a huge expense when you think about 'Am I gonna eat tonight or is my child gonna write tomorrow?'"*

Having to work long hours is part and parcel of the job, as Lilith understood from her many years of experience, *"... generally what you're looking at ... you're starting at six, half past six in the morning. You are very lucky to walk out seven or later."* Michael concurred, *"... forty-five working hours a week plus admin on top of that sometimes, you know, sometimes I've gotta do after hours stuff for that ..."* Edith also felt the pressure, *"I was probably seeing like, ja, maybe [in] excess of 30 patients a week. ... It is just hectic."* When considering that he is getting older, Lionel realised, *"I can't continue like this. I have to slow down."*

Both the private and public settings are subject to seasonal demand fluctuations, which places different types of strain on participants. The availability of medical aid benefits result in a cascade of clients vying for appointments in the first few months of each year. Lilith experienced that *"... generally from about mid January, end of January – from about there – till Easter, is extremely difficult in practice."* During this period of high demand, participants' time and energy are focused almost exclusively on their work and, in terms of self-care, Lilith did not *"... know of anyone who manages anything in the beginning of the year."* School and public holidays affect demand in clinics, and Mitch stated that *"... in the beginning of the year when the schools open we're going to have a flood."* In contrast, July is so quiet that some colleagues of Lilith who *"... haven't made financial provision, they're anxious. And even people who've been in practice for 20 years will think 'Will anyone ever phone me again?'"* In the clinic setting, Estell observed a similar decrease in winter, *"... in the colder months um, we don't see... it's, it's typically a bit quieter in colder months ..."* Lilith explained that, after July, the demand in private practice grew again until *"... generally around October, November, it feels like the world is about to end, because now they're all hospitalised, because those are the only benefits they've got left."* Regarding the increased number of cases at clinics from around springtime, Estell speculated that *"... as things um tend to warm up in, in terms of temperature, people socialise more and drink more, which leads to trauma, whether it's accidents or um fights or um, domestic disputes flare up in that time."*

Participants observed that the regulatory issues faced by psychologists in South Africa contributed to their occupational challenges. The debate around scope of practice, dealing with medical aids, and the envisaged National Health Insurance caused a lot of strain. Edith explained, *"... the future of this source of income, you know, if the medical aids, you know, aren't practicing anymore or if they completely decide 'we're not paying counselling*

psychologists', you know, that, that all contributes to that sense of like, that burnout, that anxiety, that uncertainty about the future." These issues evoked strong criticism from Lilith, who contended that regarding regulatory issues the HPCSA Professional Board of Psychology was *"... completely and utterly useless."*

In addition to the above issues, governmental oversight in the form of the national lockdown impacted participants. Private practices were much quieter, and some medical aids cut tariffs for online therapy sessions. As Michael pointed out, *"... can you imagine their [psychologists without adequate financial resources] stress levels now during these times [of lockdown] when there's no income or very low income? Because a lot of people don't feel comfortable doing Skype therapy or Zoom therapies."* The public health setting was also affected, and Estell mentioned that *"... with this lockdown we've had many presentations to the clinic where people come and they ask for... um, they need the crisis intervention right now. ... The people want to be admitted to escape their situation."* Mitch remarked that the lockdown restricted access to clinics, while at the same time *"... my work has become more... different in the sense of I'm also seeing other categories now. But ironically it is even now more stressful because we're dealing with the whole COVID-19 situation."*

The theme of occupational challenges matches some aspects from previous studies. In a phenomenological study with eight Swedish clinical psychologists, the pressure of administrative tasks, having to see a high volume of patients, and seeing complex cases were highlighted as causes of work-related stress and compassion fatigue (Norrman Harling et al., 2020). The regulatory issues mentioned by participants were not discussed in the literature consulted and may represent a novel aspect for further exploration.

6.3.1.2 Client-related challenges.

The challenges of being a psychologist also include the subtheme of client-related challenges. The type of clients seen in therapy affected the experience of participants, and

individual preferences came into play. Edith experienced couples counselling as *"... some of the most exhausting and draining ... that one can do ..."* Lilith preferred acute trauma cases, observing that *"... your chronic trauma, your childhood trauma, early traumas, that's a completely different ballgame ..."*, while she didn't *"... do well with clients that are boring."* Having to regularly see traumatised clients, Mitch realised that *"... there is a side of me not wanting to work in trauma for the next 10 years."* Estell mentioned facing a variety of challenges due to the behaviour of clients during a session, *"I've had instances where my patient pulled out a knife in my office to, um, to self-mutilate ... I've had someone take an overdose in my office. I've been bitten by a child in the middle of a temper tantrum."* While Lionel did not specify which clients he found more challenging, he mentioned approaching a phase in his career where he planned *"... to work less and do more of the work that I really enjoy, the type of cases, you know, and topics."*

Harassment by a client featured as a very real added stressor that can take different forms. Estell has had to deal with an obsessed client who *"... started to threaten and harass me and my loved ones, which was very traumatising for me ..."* Michael recounted having *"... worked with borderlines who don't think twice to take you to the Health Professions Council and make some frivolous vexatious claim."*

Participants felt a weight of responsibility towards their clients. This perceived responsibility often led to prioritising client needs, sometimes to the detriment of themselves and of the people close to them. Despite the fact that it is challenging to see clients when suffering from high levels of stress or burnout, Mitch explained that *"... it is just what you do. ... And when I'm then with a client, ... in that time it is about the client. So in a way I, I put myself aside then."* As mentioned in a qualitative study with South African psychologists (Kally, 2017), this presence during therapy represents an expression of compassion with the client. Edith also voiced her experience in prioritising client needs, *"... so that kind of like*

deep sense of responsibility we often feel towards our clients, you know, is a contributor to that emotional exhaustion and eventually burnout, because people are so needy, they are so dependent on you, and you feel… so responsible that, you know, you kind of put your own self-care secondary." Estell felt it was unfair to her family, *"… sometimes I'm, I'm exhausted and I don't necessarily have the capacity to be there for my loved ones in the same way that I'm there for my patients."* Edith commented about colleagues who have children, *"… eventually, you know, their own families start to suffer, and their own families end up being neglected and, you know, not given priority."* Even though Michael loves his works as a therapist, he was realistic, *"… but still the work is tiring and it is stressful and you work with a huge amount of um… responsibility. I mean people really wanna commit suicide, people are really at the end of their tether, people suffer with mental illness."*

The deep responsibility participants felt towards clients was similar to what Swedish psychologists described in Norrman Harling et al.'s (2020) study regarding feeling pressure to always show compassion and their personal relationships sometimes being affected by compassion fatigue.

6.3.1.3 Negative effects.

The negative effects experienced by participants due to their profession included physiological and psychological aspects. Physiological indicators included aspects such as a chronic stress response, physical exhaustion, insomnia, and falling ill. Lilith linked her elevated stress arousal to trauma work, *"… when you've worked routinely with severe trauma, you yourself undergo changes. You are on, let's – for want of a better term for the moment – say that you have heightened adrenalin levels. You get used to that."* Exhaustion and health problems were mentioned as signs of negative effects starting to take a toll. Regarding the timing of the online questionnaire of the first phase, Edith half-jokingly said, *"… if I had filled that out at – let's say – the end of last year, you'd be like phoning the*

ambulance coming to fetch me …" Mitch recognised being negatively affected *"… when I start having um, sleepless nights, insomnia, this kind of one-two-three-awake every night."*

When describing the experience of negative effects, Edith touched on how it affects the therapeutic space, tellingly using a second person narrative, *"… you're sitting with that client and you feel very disconnected from them, and you just inside just feel absolutely almost numb. … That connection is lost. And there is no desire to connect either."* Estell also related periods of burnout with a degree of dissociation, *"… it's like I'm, I'm present in body but not in mind so much."* At the end of the year, when these effects peaked for Edith, *"… you kind of feel like, um, 'I have nothing left to give, I can't', you know … You sit there and you're listening to people and you kind of have the sense of 'I actually don't care, just shush and go away.'"* Edith's explanation epitomises Figley's (2002) description of compassion fatigue, including both the diminished capacity for dealing with clients and decreased interest in their suffering. Estell painted her experience of feeling overwhelmed by her work, *"… there are times that I feel completely flooded and I'm, I'm just going through the motions: get up, work, eat, go to sleep, repeat, repeat, repeat. And then there comes a time that I feel that if I'm gonna see one more patient, I'm gonna be a patient myself."* Related to this feeling, the harassment Estell went through *"… made me rethink whether I want to be in this job, whether I'm willing to deal with someone that is really that sick, um… Yes, someone else's sickness can to some degree also be contagious, and make me sick as well."* Mitch noticed the negative effects *"… when I start withdrawing from others. So I become a bit more irritable with people."*

Lilith described having to deal with intrusive images, *"… say I saw someone who did something or other horrible, okay, um… and I was stupid enough to go to Pilates, that would be the height of stupidity, because there's no way in that instance, you'll remove the images, you can't."* These intrusive images after exposure to graphic descriptions during therapy

highlights the experience of one of the symptoms related to PTSD − a hallmark of secondary traumatic stress (Figley, 1995). Of note is that Lilith also had this reaction after working with perpetrators describing their actions and not only from working with victims. An experience that matches how vicarious trauma includes changes in one's perception of the world (McCann & Pearlman, 1990) came from Mitch, *"... your whole... outlook on life changes. You become very different, um... in how you see life. Life becomes much more a frightening world out there."*

The experience of negative effects described in this theme provides support for the disrupted cognitive schemas, intrusive memories, and changes in arousal and reactivity as reported in a qualitative study with six South African psychologists who worked with survivors of trauma (Sui & Padmanabhanunni, 2016). The negative effects experienced by interview participants also paralleled those reported by Killian (2008) from interviews with 20 clinicians involved in working with survivors of child sexual abuse. These effects included sleep disturbances, feeling distracted, lack of energy, and stress arousal (Killian, 2008). Among six New Zealand counsellors, the importance of self-monitoring for signs of stress (such as insomnia) was reported in the study of Lin and Wilson (2019). From the participant accounts in this study, each participant appeared to be aware of how negative effects manifested for them.

6.3.2 Rewards of being a psychologist.

The second main theme, rewards of being a psychologist, represents positive experiences flowing from the practice of psychology. This theme includes the satisfaction derived from therapy outcomes and the attitude of participants towards the profession.

All the participants referred to positive therapy outcomes as rewarding. These outcomes contributed to participants feeling that their work had meaning and a beneficial impact. Edith valued feedback that validated *"... what I am putting into this, the emotional*

energy, the compassion, the … it's good enough that, you know, you are making some kind of impact and then there is that sense of like, okay, a job well done." Estell experienced *"… a sense of satisfaction when I'm trying to teach someone something, and they take it to heart and they apply it."* For Lilith, trauma therapy held rewards, *"… working the field of trauma, people get better most of the time. But especially acute trauma, it's very quick, generally easy to work with, um, get good results, um, people recover quickly …"* Mitch explained that *"… starting to see the resilience of people that's going through the whole trauma, … becoming a survivor – so from victim to survivor – started giving me more hope. Um, and seeing what people were able to do. … They have learnt skills, they've learnt ways of dealing with the horror and with the trauma. And, and they can deal with that in life."* Michael expressed, *"… the positive aspects include the, the transformation I see with my patients on a very regular basis: suicidal people who rediscover their um, love for life. I see really astounding results in my work. That gives me a lot of pleasure."* Lionel observed that *"… most definitely there is a change, and what I like about it is that it's not a change with effort …"*

Some of the participants associated specific therapeutic modalities with the positive outcomes of therapy. Lionel, for example, uses hypnosis for at least half of the sessions, noting, *"… when you do hypnosis, you are actually extremely calm, and you're protected against, you know, the trauma of your clients that you see. … The nice thing about it also, is that most of your clients and patients that you see, you don't have so many sessions."* Participants' observations suggest that being skilful and experienced in specific modalities reduces the effort required on the part of the therapist. Even when facing burnout, Lilith remarked, *"I know what to do, I know the steps, I've been down that road a thousand times, so that's really not a problem."* The efficacy of "using the right tool for the right job" was part of Edith's experience, *"I had structure, I had guidance, I knew what I was doing, … I*

feel confident in what I'm doing, and it's made me feel better about couples therapy." Michael has a variety of specialised modalities to choose from. He confessed to being *"... very keen to get results with my patients. You know like, for me, if they come week after week and they complain about the same thing week after week, it feels to me like I'm doing something wrong."*

The attitudes of the interview participants towards their profession seemed to be related to their respective levels of burnout − with low burnout participants conveying unmistakable enthusiasm. Participants mentioned variety, meaning, and purpose gained from their work, all of which contribute to a positive attitude. Estell explained, *"I find it very rewarding and um, this is a very self-serving aspect, but I'm a very curious person and it just brings some diversity to my life. ... So yes, I find my job interesting and I feel that it, it builds me, and it contributes to my life in many ways."* This sentiment was echoed by Michael, *"I love what I do, because every patient is different, no single one is the same. ... So I, you know, so many aspects of my soul is being fed. I get a lot of meaning from it, a lot of purpose from it. ... If I don't do this, I don't know what I'll be doing, 'cause I really enjoy doing this. ... And I'm hoping to be an 80-year-old psychologist one day."* Similarly, although Lionel considered scaling down his work as he gets older, *"... this is exactly why I see myself working till the day my head just drops, you know (laughs), I love what I do."* Even with challenges such as the ebb and flow of demand, Estell accepted, *"... it is like there's this, this calming sense of balance um, which I'm really thankful for and I've started to, to learn to trust the process."*

Among the high burnout participants, the focus included a need to feel competent (Edith), identifying with the profession (Mitch), and Lilith's preference for quick results, *"... at the moment I want them better and out of my office as quickly as possible."* Edith expressed that *"... if you have a sense of competency in what you're doing, um, you know, because it just gives you a sense of that efficacy and that sense of 'What I'm doing is good*

enough,' …" When visualising his continued work as a therapist, Mitch shared, *"(Long pause) There, there was originally for me when you said that a feeling of 'I'd better exha… exhale now,' which I did. Um (sigh)… but it doesn't feel bad. … I already know that is what I am going to do. Um… it, it is something that… it fits me. It is for me a way of life."*

The rewards participants experienced from practising as psychologists support the comments of Swedish psychologists who expressed joy from being able to help patients and having diversity in their work (Norrman Harling et al., 2020). All these aspects point to the construct of compassion satisfaction (Stamm, 2010).

6.3.2 Self-care facets.

The final theme explores the facets of self-care that participants put into practice. The sub-themes are work-related self-care and personal self-care.

6.3.2.1 Work-related self-care.

As a facet of work-related self-care, managing the work setting featured prominently in the interviews. Limiting bookings and working hours worked for some of the participants. Edith explained, *"I got to a point where I was booking lunch hours, because otherwise I was seeing eight patients straight."* Receiving requests for after-hours sessions from clients in need were difficult to refuse, but Edith was practising setting boundaries, *"I've learnt to say no, because then I'm only getting home at seven o'clock, eight o'clock and then, you know, it starts again."* Estell also limited the number of patients she sees per day, because *"I feel that if I'm not okay, I will not be able to help someone else be okay. And if I'm so exhausted, I won't have the full capacity to, to give my best service to the person sitting in front of me."*

Being able to determine the types of clients seen for therapy seemed to be an aspect of work-related self-care for some participants. Apart from working less, Lionel had been planning to *"… do more of the work that I really enjoy, the type of cases, you know, and*

topics." Lilith favoured limiting certain clients, *"... at the moment I'm trying not to get involved in too much chronic trauma."* Since Edith found couples counselling draining, she considered, *"... maybe, you know, I must just see one couple a day, instead of... sometimes I have had two or three in a row and then I'm just finished."*

Participants shared that choosing the sequence of appointments contributed significantly to self-care in the work setting. Both Estell and Lilith employed this approach, noting that they needed to sequence sessions themselves, since they know their own "rhythm" and how the therapy process of each client was progressing. Estell commented, *"... if it's a, a difficult case I will place them before lunch, so that I have a break after that. Um, or at the end of the day when I get to leave the context and I won't have to deal with other people altogether. And then I sometimes also try mix up more um... enjoyable, easier cases with the more difficult cases, so the one person's effect neutralises that of the other."* Lilith explained, *"I will not put certain... people who are a certain way along the process next to each other, it's too demanding. So I would intersperse them with other people that I know: this is a follow-up session, or it's the intake, or... um, I know we're gonna do this, um, this is a 'bring things together', it's not going to be an issue, it's not emotionally demanding."*

Employing an office manager enabled Michael to see more clients without non-billable interruptions – such as asking a recommendation for a therapist in a different city – during the day. He stated that he may reduce the number of sessions when he is older, *"I might not see nine patients a day, I'll see four or five perhaps (laughs)."* He considered his work setting idyllic, *"I work from home. I have arranged my life that um... I look out on my garden, I've got a beautiful garden outside."*

Additional training in specialised modalities greatly contributed to professional self-care. Participants experienced greater competence, less effort, and better outcomes when being able to use specialised skills. Edith explained the need for further training, *"...*

sometimes we do feel a bit like we're feeling around in the dark, um, because we don't always have training, especially in those starting out. Master's is an overview." Specialised training, Edith felt, *"... literally changed my life."* Estell also prioritised additional training, mentioning that *"... my private practice I've always treated more for um, let's say spending money. I'm paying for more expensive courses that I wouldn't necessarily be able to pay for just based on my state salary."* Even though further training can be costly, Michael did not regret the expense, *"... because I'm using it, because I'm seeing the results, because I use that same stuff I've learned for my patients."* Receiving training in fields other than trauma was part of Mitch's self-care, *"I find ... going to do training and engage with people in other fields, um to be very positive."*

In addition, many of the training courses included practising techniques with other trainees, and some participants have found this a valuable way to advance their own psychological healing. Lionel commented, *"... during your training – the [hypnosis] training I did – seventy percent of the time you actually have to work with your own problems or issues, which I did."* Michael agreed, *"... so a lot of my healing I've done it 'coincidentally', by doing the trainings. ... So for me um, emotional, um, personal transformation and educational learning new stuff often goes hand in hand."*

Input from colleagues was mentioned as part of self-care. This included supervision, own therapy, informal discussions, and support groups. Edith found working in a shared practice helpful, *"... there's a shared sense of confidentiality, all of that, I mean, you can, we can discuss cases with each other, you know, and provide support as needed."* Estell regularly enjoyed informal debriefings with a colleague, *"Someone to do some reality testing with at the end of the day ..."* She was also in supervision for more difficult cases and said, *"... that's one of the things that's really helping me a lot. This fact, the sense of professional and collegial validation for, for my experiences."* Even during the busiest season, Lilith

mentioned fitting in online supervision for a colleague, *"... because that's about the best you'll manage."* Mitch mentioned, *"I do still attend, um therapy. I've done it over all the years that I've been working in this place, and I still do that."* Even though Michael has found additional training therapeutic, he also stated, *"I've done a fair amount of going to see psychologists."* Lionel expressed an important perspective, *"... to be able to receive as well, and not just give, is vital. Which I've done during my training, but also at, you know, after certain traumatic experiences. I actually went to colleagues that obviously have the same approach that I do, and I've experienced that first-hand, you know, the effect of it."*

The perspectives of the interview participants corroborates the findings of Killian (2008) who reported self-care strategies employed by clinicians to include processing with peers, supervision, engaging in continuing education, and learning new techniques. The participant perspectives also echo professional self-care areas mentioned by New Zealand counsellors, which included regular breaks, continued learning, and support from supervisors and peers (Lin & Wilson, 2019).

6.3.2.2 Personal self-care.

From participants' comments, personal self-care varied based on personal preferences and included not only taking action but also limiting activity. One central aspect, however, was self-compassion. One way mentioned to exercise self-compassion included accepting being human. Michael reflected, *"... being a joyous psychologist and a joyous human being has helped me tremendously, uh, to, to have a much softer approach towards my life."* For Lionel, *"... when you deal with trauma in your own life properly, ... you are actually allowing yourself to be human."* This is important for therapists, as Lionel conveyed, *"... when you deal with that [own trauma], if you have compassion for yourself, if you take time out for yourself, you reflect, you read, you talk to people, and... if you do that, you can actually open up to other people as well. And you create a space for them because you create*

a space for yourself." This perspective agrees with Kally's (2017) finding that the acceptance of self and others moved psychologists to experience more compassion and stronger connections with their clients. Mitch had learnt over time, *"I don't have to be strong. I don't have to cope. I don't have to be this image of this strong parent – for example – for my kids. … I don't need to be this… ja, strong, 'in control' person anymore. I, I can just be me."* This sentiment echoes how South African psychologists conveyed the importance of accepting being human and having imperfections to the ability to express self-compassion (Kally, 2017). Working at both the clinic and part-time in a private practice, Estell realised, *"I had to give up on this notion of being the perfect accomplished housewife who could cook meals and had a clean house, and all that. So this job would be my third job then, 'cause I already had two jobs."*

Honouring one's own needs featured as a way to express self-compassion. As Edith had noticed, *"… the more you start to feel that emotional drain and exhaustion, the more you realise 'Hey, you know what, I actually come first.'"* For Mitch, enacting self-compassion can include *"… just go and sleep, or just lie down and have a good cry, that is also an act of self-care, although it looks very different than I would have structured it originally."*

Another central aspect to personal self-care is taking time out on different levels. For the individual participants, taking time out from work included short breaks between sessions, evenings at home, weekends away or longer holidays. Edith incorporated a few minutes of guided paced breathing between sessions. She stated, *"… and I found now that that 'just stopping' just for, even just a few minutes, it makes a difference. There's so much going on around you and inside you. To actually just almost disconnect from that for… a couple of moments, and just gather yourself, it kind of helps you get through, let's say the next hour."* Mitch created time out by playing games such as Sudoku, *"… stuff that I can organise and categorise, and put into place. … And as I do that I have time to think and process. So it's*

in a certain way (laughs) putting the logical side doing something and, and dealing with the emotions." Mitch also mentioned another way to disengage from trauma work, *"I found being with my children being exceptionally good for me. … I can be in the moment with them."* Estell said, *"… my husband and I take, try to take regular breaks away from home. … We try to um, go out on a little um, weekend away for, to just explore things. … And then two or three times a year we try to go for a bit of a longer break, just to really get away from the, the everyday."* Taking time for creative activities was something Lilith did in quieter times, *"I paint when I can, I used to try and do it Sunday evenings as a transition, but I simply don't manage to fit it in now."* Michael voiced loving his work but also declared, *"I normally close between about the fifteenth of December till the first week of January. It's also nice to go on holiday and to do something else for that time."* Participants in Hitge's (2015) study about the well-being of South African psychologists similarly highlighted taking breaks and going on holiday as part of their self-care activities.

Time for solitude was essential to most of the participants. The "peopling" business, as Edith called it, can be exhausting, *"… so my self-care has to be, like, isolation, spending time by myself to recharge, you know, no demands or pressures on me. … I need to have that kind of bubble-time where I have no people interaction."* Estell, on the other hand, enjoyed some socialising interspersed with time alone. She observed, *"I need to, to practise – um let's call it efficient dosage – not too much isolation, but not too much socialisation."* Lionel expressed his gratitude that he had time for self-reflection, *"… fortunately our children have left the home now, and they're out, but the wonderful thing for me in my marriage is that my wife and I can give each other that space."* Mitch also received support for solitude at home, *"… sometimes I would just withdraw and sleep, and there fortunately my partner understands."* The time for solitude described by participants reiterates the need to isolate for

the purpose of self-regulation as reported by Hitge and Van Schalkwyk (2018) in a study with South African psychologists.

Similar to the current study's subthemes, a study exploring the self-care practices of six New Zealand counsellors also indicated that both personal and professional self-care were practiced by the counsellors (Lin & Wilson, 2019). Furthermore, the varied ways in which participants in the current study applied facets of self-care supports the Lin and Wilson (2019) finding that, regardless of similarities in aspects of self-care, counsellors dealt uniquely with their self-care.

6.4 Integration of Quantitative and Qualitative Results

This study included a quantitative phase and a qualitative phase conducted in a sequential manner. The explanatory purpose of the qualitative results is integrated in this section.

The results from the first phase suggested that significant differences exist between the early and late career groups regarding positive (compassion satisfaction) and negative (compassion fatigue and burnout) aspects. The late career group reported higher compassion satisfaction and lower compassion fatigue and burnout scores.

The positive construct compassion satisfaction can be linked to the second theme identified in the qualitative phase − rewards of being a psychologist. A significant negative relationship was demonstrated between not only compassion satisfaction and compassion fatigue but also compassion satisfaction and all three burnout subscales. This suggests a buffering role of compassion satisfaction against the negative effects. Those interview participants with low burnout scores (Estell, Michael, and Lionel) expressed pleasure at seeing the positive results of therapy with their clients and displayed an enthusiastic attitude towards their profession; both associated with compassion satisfaction. Even though the high

burnout interview participants (Edith, Mitch, and Lilith) also appreciated positive outcomes and feedback, their experience of compassion satisfaction was muted.

The significant difference in compassion satisfaction between the early and late career stage may be linked to several aspects highlighted in the qualitative results. Additional specialised training, modalities used, type of clients, and years of experience appeared to play a role in the outcomes attained. Late career psychologists may be able to select the types of clients to see in therapy, which may contribute to positive outcomes.

The higher compassion fatigue score distribution in the current sample and the positive relationship between trauma therapy sessions per week and compassion fatigue, may both point to the risks that South African psychologists face in view of the context of their lives and work (see 1.2). Both constructs related to negative experiences, compassion fatigue and burnout, are recognisable in the first qualitative theme − challenges of being a psychologist. The subtheme describing the negative effects identified physiological exhaustion, an aspect related to personal burnout on the CBI. Experiencing the additional tasks related to administration as a burden could likewise indicate work-related burnout. Furthermore, having "nothing left" to connect to and deal with clients signified compassion fatigue and client-related burnout. Intrusive images, stress arousal, and the resulting insomnia clearly pointed to the construct of secondary traumatic stress (Figley, 2002). The elevated compassion fatigue distribution may also be related to challenges that psychology professionals in South Africa face, such as regulatory issues and uncertainties (see 5.2.5.1). The significant difference in compassion fatigue between the late career group and the less experienced groups also reflected that late career psychologists were less affected by uncertainties in the regulation of their profession, while those with a long career path ahead of them faced a much stronger impact on their future prospects.

The mostly significant relationships between the self-care dimensions and compassion satisfaction, compassion fatigue, and burnout in the expected directions were elucidated by the qualitative data. Participants applied self-care proactively and reactively. Work-related self-care, such as additional training, managing the work setting (where possible), and being willing and able to rely on input from colleagues, counteracted the negative effects of psychotherapeutic work. Additional specialised training reduced the effort required from therapists, enhanced their personal growth and healing, and contributed to the satisfaction of seeing the results of therapy in their clients.

Although personal self-care was enhanced by self-compassion, this was hampered by available time − which reflects the negative correlations between therapy sessions per week and the daily balance and life balance subscales. The life balance subscale (which equates spending time with people and building social connections to self-care), however, would not provide a valid measure for a strongly introverted psychologist who considered a complete break from people as restorative.

The standard multiple regression showed that burnout, whether per subscale or combined, is a strong predictor of compassion fatigue. The seasonal changes in occupational challenges featured prominently in the qualitative theme, the challenges of being a psychologist. When considering the negative effects of practising psychology, the qualitative data indicated that the intensity of these experiences vary over time − at times being mild and at times more intense. The collection of the quantitative data at a specific point in time did not take into account these temporal fluctuations.

6.5 Limitations of the Study

Although the present study is subject to a number of limitations, the sequential mixed-method study approach produced valuable findings. The following limitations should be considered when interpreting the results of this study:

- The representativeness of the quantitative sample was weakened by the challenge of having to find the contact details of psychologists online. In addition, almost 85% of the participants of this study work primarily in private practice.
- The timing of the study is a limitation, as it was conducted at the beginning of the year. The data represented only a snapshot of the professional quality of life of psychologists at that time, soon after a holiday period. Taking into account both the seasonal nature of demands on psychologists and the remarks of interview participants, considerable variation in assessment scores is possible over the course of a calendar year − with negative effects peaking at the end of the year.
- Due to the cross-sectional nature of the study, no causal relationship can be inferred for the constructs measured in the quantitative phase. In addition, the cohort effect must be kept in mind since the political and professional landscape in South Africa has changed considerably in the last two and a half decades.
- The quantitative phase included only self-report measures. The responses could have been influenced by social desirability bias and by the sequence of the assessment measures.
- All measures used need to be further validated among the South African population.
- The biographical section of the quantitative questionnaire did not define the term “trauma client”, therefore the number of trauma therapy sessions per week may have been interpreted in more than one way, which impacts the reported numbers.
- The national lockdown regulations due to COVID-19 prevented face-to-face interviews for the qualitative phase. The flow of the online interviews conducted due to these restrictions was affected by insufficient quality in data connection. In addition, the online interaction hampered the development of rapport that personal interaction could have established.

The limitations as discussed should be considered and rectified as far as possible in future research studies. The next section details recommendations for consideration in future research.

6.6 Recommendations for Future Research

Based on the limitations described, the following recommendations for future research are offered:

- Research using a larger random sample that includes private and public South African psychologists alike would produce a more generalisable outcome. Attempting to increase the participation of different language groups would also make the results more representative.
- Setting a minimum number of weekly therapy sessions as one of the inclusion criteria may provide a better foundation for the assessment and comparison of constructs.
- Collecting data at a few different times during a calendar year will produce more representative data regarding the impact of seasonal demands.
- Longitudinal or retrospective research could investigate whether the differences in career groups are due to the psychologists who suffer higher levels of negative effects leaving the profession (or the country) or psychologists developing resilience to the challenges of the profession over time. In addition, qualitative research with psychologists who have left the profession or the country could supply more insights into their motivation and past experiences.
- Longitudinal studies could shed light on causal relationships, rather than highlighting correlations among variables measured at one time.
- Augmenting self-report measures with physiological measures would add a degree of objectivity and triangulation to the results. These measures might be interpreted through

the lens of the polyvagal theory (Geller & Porges, 2014) − linking the functioning of psychologists to the therapeutic space they possibly create for their clients.

- In addition to assessing constructs and physiological parameters, experimental research would provide useful insights. Experimental designs could evaluate the efficacy of techniques meant to reduce compassion fatigue, burnout, and stress among psychologists.
- Data from the original ProQOL Version 5 (Stamm, The concise ProQOL manual, 2010) in past research could be analysed according to Heritage et al.'s (2018) alternative scoring, which would produce more broadly representative cut-point scores to assess the vulnerability or resistance to adverse outcomes when utilising the ProQOL-21.
- When collecting biographical data around trauma therapy, the term "trauma client" should be clearly defined.
- Obtaining more extensive biographical information could enhance the investigation of the relationships related to professional quality of life. Potential items include: additional training since registration, treatment modalities used, type of presentations seen in therapy, home environment (married, single, divorced, children and their ages, single income), social support, personality type, sources of work stress, sources of personal stress, primary trauma history (including long-term low intensity trauma), and self-care practices employed.
- Qualitative interviews should be conducted in person as far as possible.
- Finally, based on more comprehensive research, programmes of support and self-care for both psychologists in training and in different stages of their careers should be developed and evaluated.

6.7 Suggestions for Training and Support of Psychologists

Based on the findings of this study, suggestions regarding the training and support of psychologists in South Africa are discussed in this section. This discussion includes some suggestions from the literature.

There is a high potential for South African psychologists to be personally affected by trauma and having to work with traumatised clients. It would therefore be meaningful to include not only training specifically aimed at trauma therapy but also learning to be aware of and to understand secondary trauma. Sui and Padmanabhanunni (2016) specifically recommend teaching trainees to recognise the signs of vicarious trauma.

Maranzan et al. (2018) recommended teaching and applying self-care as a competency during training − emphasising its proactive application to protect the therapist, rather reactive utilisation to prevent professional impairment. They also suggested that self-care should form part of continuing professional development. From the results of this study, it may be advisable to include both work-related and personal self-care dimensions, while accentuating how to customise practices to suit personal preferences and needs.

Based on the comments of one of the qualitative participants, adding business skills to the training of psychologists may better equip them to face some of the challenges related to the management of their work setting and personal finances.

Considering the national lockdown during the COVID-19 pandemic, it may not be unreasonable to include training for online therapy sessions. While online therapy may have some disadvantages, it can also expand the options for therapy and be creatively used to reach more clients.

Jordaan et al. (2007b) encouraged forming support groups among colleagues and that young psychologists seek constant supervision from experienced colleagues. The current

study highlighted the subjective experience of the positive impact of input from colleagues, which included informal debriefing, supervision, and therapy.

MacRitchie and Leibowitz (2010) emphasised trauma treatment for psychologists who had been the victims of crime. Based on the moderating effect of mindfulness between personal trauma history and compassion satisfaction, Martin-Cuellar et al. (2018) also recommended the inclusion of mindfulness training in training curricula.

Radey and Figley (2007) maintained that the promotion of clinicians' compassion satisfaction may safeguard them from the detrimental effects of working with the traumatised. Cummings et al. (2018) likewise proposed the implementation of programmes aimed at increasing compassion satisfaction for both the prevention and treatment of compassion fatigue, secondary traumatic stress, and burnout.

Assessing the factors that, according to the CFR model, elevate and moderate the development of compassion fatigue (Ludick & Figley, 2017) could be useful in promptly identifying at-risk psychologists and acting to prevent the further development of compassion fatigue. This may be done during training and again at regular intervals over the course of the career span.

6.8 Conclusion

The primary aim of this study was to assess and explore relationships among compassion satisfaction, compassion fatigue, burnout, and self-care in a sample of clinical and counselling psychologists who practice in South Africa. The compassion satisfaction score distribution was similar to reported values, while the compassion fatigue scores had a higher distribution. The findings further suggested that moderate and high personal burnout occurred in a substantial percentage of the participants, a smaller percentage displayed work-related burnout, and client-related burnout was the least prevalent.

Significant differences between especially the early and late career stage groups were demonstrated for compassion satisfaction, compassion fatigue, and all three burnout subscales. The late career psychologists reported higher compassion satisfaction and lower compassion fatigue and burnout. Self-care did not significantly differ between career groups, but almost all the self-care dimensions were significantly associated with the compassion satisfaction, compassion fatigue, and burnout scores.

Additional significant relationships were shown between the number of trauma therapy sessions per week and the scores for compassion satisfaction, compassion fatigue, burnout, and some of the self-care dimensions. The regression analysis also indicated that burnout was a strong predictor of compassion fatigue, which hints at the importance of preventing and reducing burnout in psychologists. The negative relationship between compassion satisfaction and both compassion fatigue and burnout may imply that enhancing compassion satisfaction could also play a protective role against these negative aspects.

The qualitative data enhanced understanding of the complexity of factors that affect the experience of the positive and negative aspects of professional quality of life. The approaches to self-care included both shared and subjective elements.

The South African context poses its own challenges to psychologists and their clients. Preparing trainee psychologists for the challenges of the profession and supporting those in different stages of their careers can, hopefully, enhance the retention of South African psychologists. In addition, it may also aid in ensuring quality mental health care for their clients.

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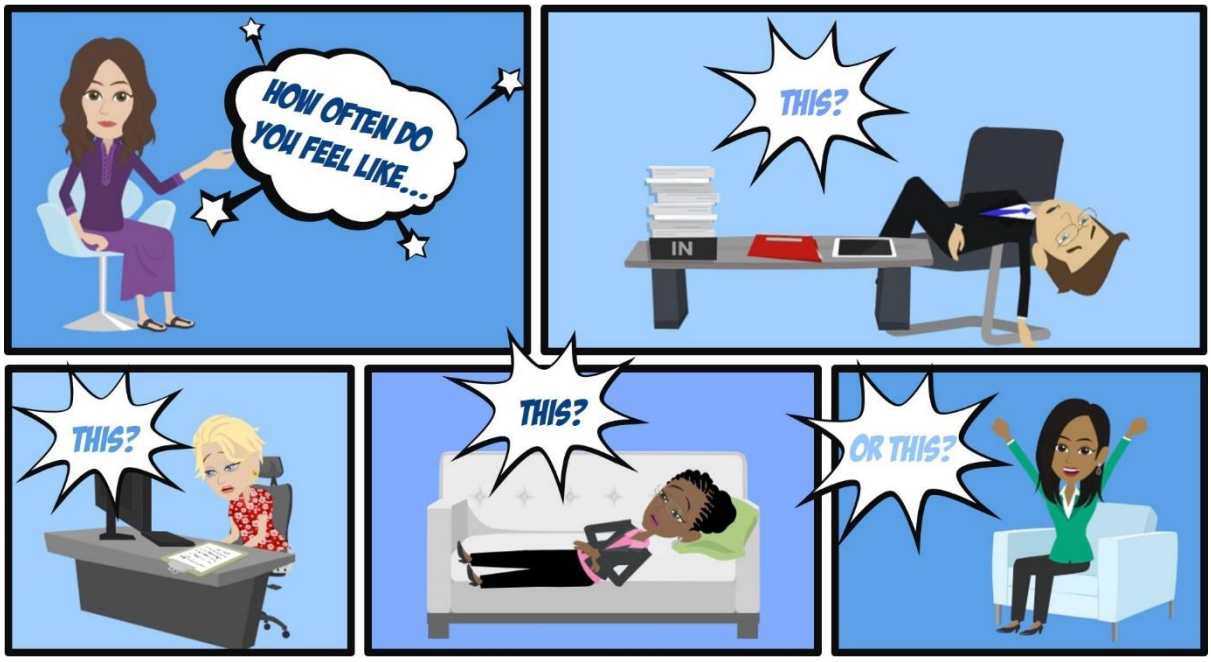
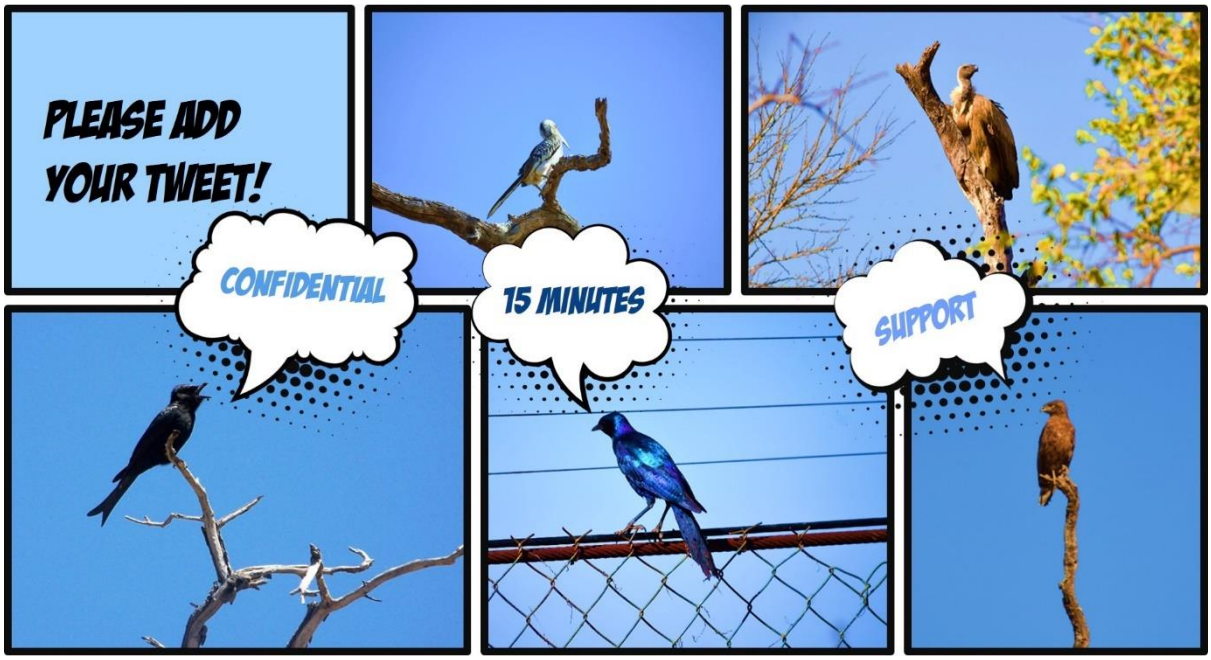
APPENDIX A: Emailed invitation and information letter for quantitative phase

Inspired or tired: Shrinks matter

Good day [title and surname]
(If you are not the intended recipient, kindly let me know)



As a psychologist you are part of a scarce and precious resource towards the mental well-being of South Africans. This research is aimed at determining whether additional support both during training and the across the career span of psychologists could be beneficial.



You have been randomly selected to participate in my UP Master's research project titled "Compassion satisfaction, compassion fatigue, burnout, and self-care among South African clinical and counselling psychologists: A cross-sectional mixed methods study."

Please complete these online assessments of about 15 minutes. Your input will be of great value to assess the aspects mentioned. Through random selection I am attempting to obtain data representative of the current status of South African clinical and counselling psychologists.

No identifying data will be entered online. The information letter is attached. Please read this to make an informed choice about your participation. If you select the unique link below, you will indicate your consent online by selecting a checkbox, so no paperwork!

Please click on this link to access the questions:
[Unique link to Google Forms questionnaire]

Should you like to clarify anything regarding your participation, feel free to contact me via email or my mobile phone number supplied below.

Warm regards

Elsemarié van der Walt
UP Student Number: 87113563
Email: evdw29@gmail.com
Mobile: 082 781 9421

Supervisor: Dr Nicoleen Coetzee

The attachment to the emailed invitation is reproduced on the next pages. It contains the information letter and details for informed consent. The consent form was electronically included as part of the online questionnaire.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Humanities 100.
1919 - 2019
Department of Psychology

Faculty of Humanities
Department of Psychology
2 Lynnwood Road
Pretoria
0002

INFORMATION LETTER AND INFORMED CONSENT

TITLE OF THE STUDY:
COMPASSION SATISFACTION, COMPASSION FATIGUE, BURNOUT, AND SELF-CARE AMONG SOUTH AFRICAN CLINICAL AND COUNSELLING PSYCHOLOGISTS: A CROSS SECTIONAL MIXED METHODS STUDY

Principal researcher: Elsemarié van der Walt
Contact details: 0827819421/evdw29@gmail.com
Supervisor: Dr Nicoleen Coetzee
Contact details: 0124202919/Nicoleen.coetzee@up.ac.za

Dear Participant

I am conducting this research project for an academic Master's degree at the Department of Psychology of the University of Pretoria. You have been randomly selected and are invited to take part in this research project. The information below will explain the details of the project and what your participation would involve if you decide to take part. Please read the information carefully before agreeing to participate in this project. Please feel free to contact the researcher via the contact details above for any additional information you need to make a decision about your participation in this study. This consent form is for the first phase in a two-part study.

Purpose of the study

Psychologists supply an essential service in the psychological well-being of the South African population, and should be protected and supported. This project is aimed at measuring compassion satisfaction, compassion fatigue, burnout, and self-care among a sample of South African clinical and counselling psychologists with varying years of experience.

Procedures

- Each participant will receive an emailed invitation to participate, containing this information letter and a unique link to an online platform.
- Should you agree to participate, you need to select the link to open the online platform where the informed consent aspects will be displayed and a checkbox needs to be checked as confirmation of your consent to participate. This will constitute similar consent as a written signature.
- Next, a short biographical questionnaire and assessments of professional quality of life, burnout and self-care will be filled in and submitted online.
- Completing the questionnaire and assessments electronically should take about 15 minutes.
- The biographical information does not include any identifying data, only the following:
    - field of registration (clinical or counselling),
    - number of years in practice,
    - primary work environment (private practice or public health),
    - age,
    - gender,
    - average number of therapy sessions per week over the last six months,
    - age group(s) of clients (children, adolescents, adults), and
    - percentage of therapy sessions with trauma clients.
- On the last page of the online assessments, the participant will be reminded of the right to withdraw, and that selecting to submit the responses constitutes informed consent.

Only a small number of participants will be invited to take part in a subsequent phase of individual interviews of about an hour each to further discuss their experiences with regards to the aspects measured in the questionnaire. Participation in the second part of the study will be preceded with a separate consent form.

Risks

Risks to participants are minimal, as the online form can be filled in online at the participant's own venue of choice.

Benefits

No incentives are offered for participation in this study. Completing these assessments may benefit you through improved self-awareness and self-care practices. Your participation will contribute to academic research. The insights gained from this study may also benefit psychologists in general by leading to enhanced training and support.

Participants' rights

Please take note of your rights:

- Your participation in this study is voluntary.
- You have the opportunity to ask questions about the study before agreeing to participate.

- After agreeing to participate, you may withdraw from participation in the study at any time without having to explain why and without negative consequences.
- You have the right of access to your data.
- If you are selected for the next phase, you have the right to decline to participate in that phase of the study, and the right to withdraw at any time from the second phase of the study without negative consequence.

Confidentiality

- All data supplied on the online form will be treated confidentially.
- Replies in the online form will only be linked to a numeric code to protect participants' privacy.
- The randomly generated codes for participants will be saved in a password-encrypted file accessible to the researcher, Elsemarié van der Walt, for the purpose of selecting participants for the second part of the study.
- Should the participant choose to withdraw from the study, the data collected for that participant will be destroyed.
- Data collected might be anonymously used for future research purposes.
- De-identified data will be stored in the Department of Psychology for a minimum period of 15 years.
- Access to the de-identified research data will be limited to:
    - The researcher – Elsemarié van der Walt
    - The supervisor – Nicoleen Coetzee
    - Internal and external examinators
    - The Department of Statistics of the University of Pretoria
    - The University of Pretoria Library Services
    - Should an article be published in an academic journal, the readers of the article
    - The participant, should he/she wish to see the results of the study.

Access to the researcher

Should you require any clarification regarding this study, you are welcome to contact the researcher via the email address or mobile number supplied.

Thank you for your willingness to consider contributing to this research project about the psychology profession in South Africa!

Sincerely

Elsemarié van der Walt
Researcher
University of Pretoria

APPENDIX B: Information letter and informed consent form for interview

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Psychology
2 Lynnwood Road
Pretoria
0002

INFORMATION LETTER AND INFORMED CONSENT FORM FOR INTERVIEW

TITLE OF THE STUDY:
Compassion satisfaction, compassion fatigue, burnout, and self-care among South African clinical and counselling psychologists: a cross sectional mixed methods study

Principal researcher: Elsemarié van der Walt
Contact details: 0827819421/evdw29@gmail.com
Supervisor: Dr Nicoleen Coetzee
Contact details: 0124202919/Nicoleen.coetzee@up.ac.za

Dear Participant

Your participation in the first phase of this study is greatly appreciated. You have been selected and are invited to take part in the second phase of this research project. The information below will explain the details of this phase. Please read the information carefully before agreeing to participate in this phase. Feel free to contact the researcher via the contact details above for any additional information you need to make a decision about your participation in this part of the study. This consent form is for the second phase in the two-part study.

Purpose of the study
Psychologists supply an essential service in the psychological wellbeing of the South African population, and should be protected and supported. This project is aimed at measuring compassion satisfaction, compassion fatigue, burnout, and self-care among a sample of South African clinical and counselling psychologists with varying years of experience. This second phase aims to better understand the data from the first phase survey.

Procedures

- Each participant will receive an emailed invitation to participate in this second phase of the study, containing this informed consent document.
- Should you not reply within a week of the invitation, the researcher will follow up with you via email.
- The researcher will mail you a printed consent form, which you need to sign. The scanned (or electronic) signed form may then be returned via email to the researcher.
- If you are willing to participate, the researcher will arrange an online meeting via the Zoom platform at a time convenient for you. You will need either a computer or mobile device and data access. During this meeting the researcher will ask you questions relating to your experience of the aspects measured in the first part of the research project.
- The interview should take about an hour and will be recorded with your permission. The Zoom system creates both a video and an audio recording. These files will be stored in an encrypted partition for the purpose of transcription.
- After analysis of the interview data, the researcher will contact you to arrange for a further online meeting to verify whether you agree with the analysis. The follow-up meeting may take about an hour.

Risks

Risks to you are minimal, as you will only need to reflect on your subjective experiences.

Benefits

No incentives are offered for participation in this study. Participating in this interview may benefit you through improved self-awareness and self-care practices. Your participation will contribute to academic research. The insights gained from this study may also benefit psychologists in general by leading to enhanced training and support.

Participants' rights

Should you decide to participate, please take note of the following participants' rights:

- Your participation in this study is voluntary and there will be no penalty or loss of benefit if you decide not to take part.
- After agreeing to participate, you may withdraw from participation in the study at any time without negative consequences.
- You have the right to decline answering specific questions during the interview.
- You have the right of access to your data.

Confidentiality

- All the information you supply during the interview will be treated as completely confidential.
- Should you choose to withdraw from the study, the data collected from you will be destroyed.
- The participant code used in the first phase of the study will be used when transcribing the interview to protect your privacy.

- In the discussion of the data in the research report, with your permission, anonymous quotations may be used with a pseudonym. Any details discussed that might be used to identify you will be altered as necessary to protect your identity.
- Data collected might be anonymously used for future research purposes.
- De-identified data will be stored in the Department of Psychology for a minimum period of 15 years.
- Access to the de-identified interview data will be limited to:
    - The researcher – Elsemarié van der Walt
    - The supervisor – Dr Nicoleen Coetzee
    - Internal and external examinators
    - The University of Pretoria Library Services
    - Should an article be published in an academic journal: readers of the article
    - The participant, should he/she wish to see the results of the study.

Access to the researcher
Should you require any clarification regarding this study and your participation, you are welcome to contact the researcher via the email address or mobile number supplied.

Thank you for your willingness to consider participating in this research project to assist in compiling data about the psychology profession in South Africa!

Please turn over for consent form.

Sincerely

Elsemarié van der Walt
Researcher
University of Pretoria

CONSENT FORM

Compassion satisfaction, compassion fatigue, burnout, and self-care among South African clinical and counselling psychologists: a cross sectional mixed methods study

I have read the information presented in the information letter about a study being conducted by Elsemarié van der Walt under the supervision of Dr Nicoleen Coetzee of the Department of Psychology at the University of Pretoria. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.
I am aware that I have the option of allowing my interview to be recorded to ensure an accurate account of my responses. I am also aware that excerpts from the interview may be included in the dissertation and/or publications to come from this research, with the understanding that the quotations will be anonymous.
I was informed that I may withdraw my consent at any time without penalty by advising the researcher. I was informed that if I have any comments or concerns resulting from my participation in this study, I may contact the researchers at the contact details supplied above.

With full knowledge of all foregoing, I agree, of my own free will:

- to participate in this study,
- to have my interview recorded, and
- to the use of anonymous quotations in any report or publication resulting from this research.

Participant Code:

Participant's Signature (please paste image) **Date** Click or tap to enter a date.

Researcher's Signature **Date**

APPENDIX C: Interview guide

SEMI-STRUCTURED INTERVIEW GUIDE FOR QUALITATIVE PHASE

1. How would you describe the positive aspects you experience from practicing as a psychologist?
2. How do you know when your are experiencing negative effects from your work?
3. Please tell me about your approach towards self-care.
4. How would you describe the interplay between self-care, compassion satisfaction, compassion fatigue, and burnout in your life?
5. What do you do to relax and recharge when you realise that you need to?
6. How is it for you to see clients/patients when you experience more stress or burnout?
7. What happens in your body when you visualise continuing your work as a therapist? And in your thoughts?
8. Which features would a new self-care practice have for you to be able and motivated to incorporate it into your life? (Time, effort, benefit?)

APPENDIX D: Ethical clearance

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

10 December 2019

Dear Mrs E van der Walt

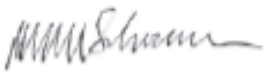
Project Title:	Compassion satisfaction, compassion fatigue, burnout, and self-care among South African clinical and counselling psychologists: A cross sectional mixed methods study.
Researcher:	Mrs E van der Walt
Supervisor:	Dr N Coetzee
Department:	Psychology
Reference number:	87113563 (HUM007/0819)
Degree:	Masters

I have pleasure in informing you that the above application was **approved** by the Research Ethics Committee on 28 November 2019. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

We wish you success with the project.

Sincerely



Prof Maxi Schoeman
Deputy Dean: Postgraduate and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: PGHumanities@up.ac.za

APPENDIX E: Other self-care practices

The percentage of participants per career group applying the respective general self-care practices included in the online questionnaire can be seen in Figure E1.

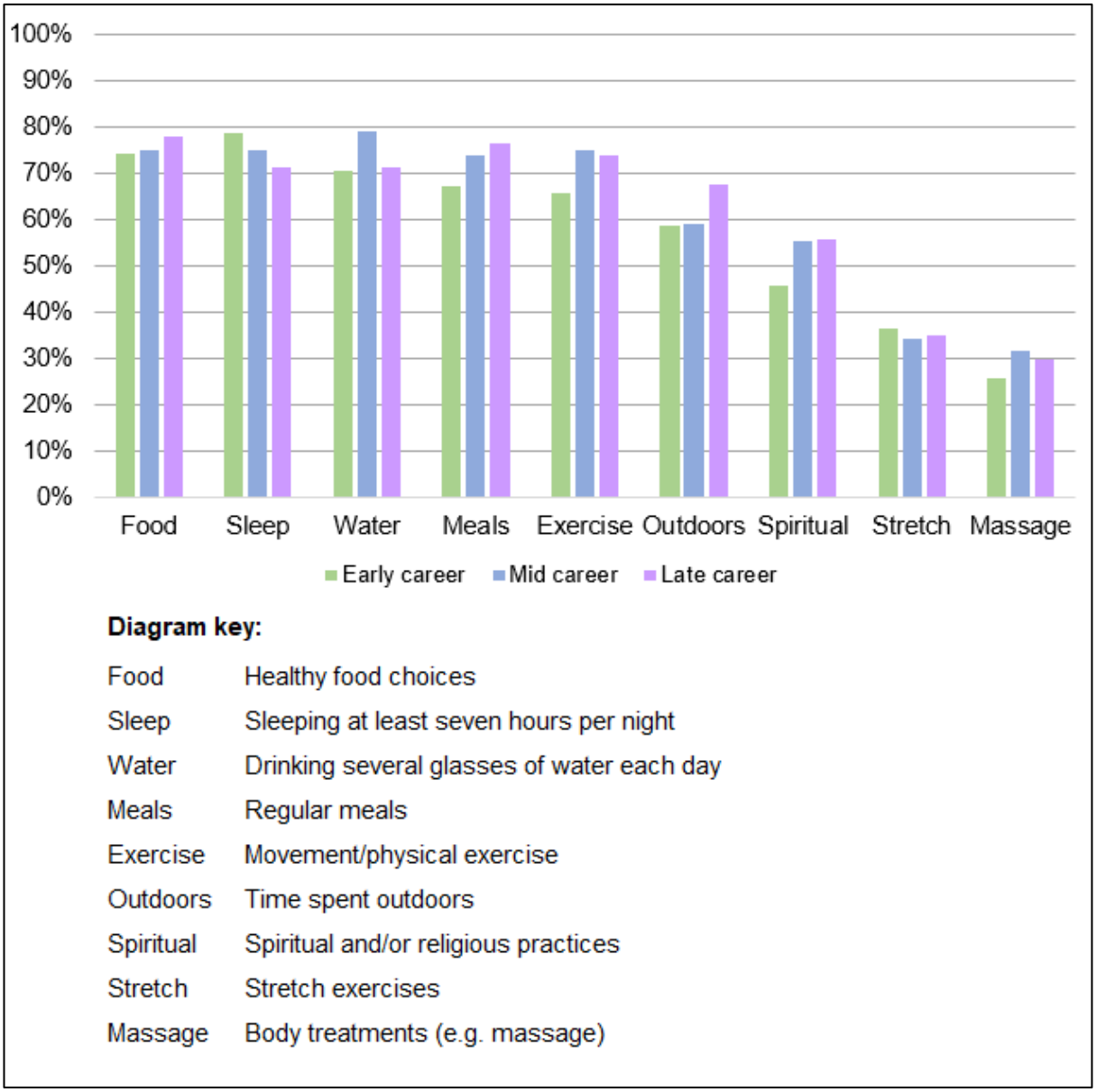


Figure E 1. Percentage of each career group regularly applying additional general self-care aspects.

The other self-care practices added by participants were grouped where similar and sorted according to frequency of being mentioned. These practices are listed in Table E1.

Table E1
Other self-care practices added by participants

Self-care practice	Number of times mentioned
Engaging with family/friends/community/own children	20
Reading/research	19
Meditation/contemplation/silent retreats/mindfulness/relaxation exercises	15
Personal psychotherapy/supervision	13
Handicrafts/hobbies	12
Holidays/weekend breaks/travel	11
Gardening/time in nature	9
TV/movies/theatre	9
Art/creativity	7
Spend time with animals/dog walking	7
Playing musical instrument	5
Yoga/breathing techniques	5
Listen to music	4
Writing/journaling	5
Cooking	2
Personal time out/alone time	2
Sports/running	2
Work part-time/limit caseload	2
Online interaction/social media	2
Health supplements	1
Long baths	1
Power naps	1
Refrain from alcohol	1
Use enjoyable therapeutic methods less taxing on therapist	1
Visiting markets	1

APPENDIX F: Graphic display of significant Pearson's correlations

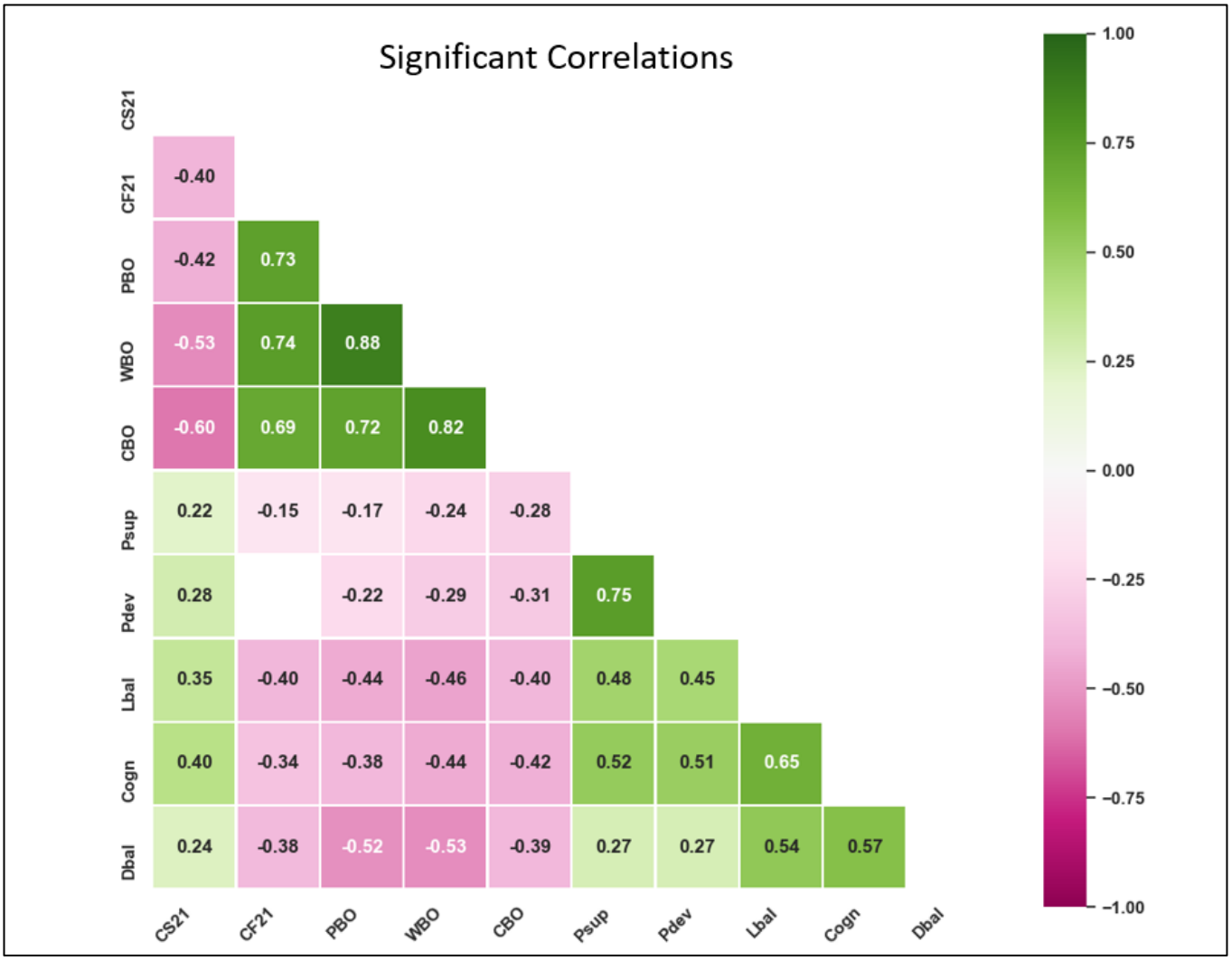


Figure F1. Significant correlations among ProQOL-21, CBI, and SCAP constructs

Note: CS21 = compassion satisfaction; CF21 = compassion fatigue; PBO = personal burnout; WBO = work-related burnout; CBO = client-related burnout; Psup = professional support; Pdev = professional development. Lbal = life balance. Cogn = cognitive awareness. Dbal = daily balance.