TITLE

Experiences of clinical psychologists working in palliative care: a qualitative study.

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ABSTRACT

Background: Compassion fatigue refers to the emotional and physical exhaustion felt by professionals in caring roles, whereas compassion satisfaction encompasses the positive aspects of helping others. Levels of compassion satisfaction and fatigue have been found to

be inconsistent in palliative care professionals, which could have serious implications for patients, professionals, and organisations.

Objectives: This study explored the experiences of clinical psychologists working in palliative care, all worked with adults with cancer, to gain an understanding of the impact this work has on their self and how they manage this.

Methods: A qualitative approach was taken, using semi-structured interviews and interpretative phenomenological analysis.

Results: Three superordinate themes were identified: commitment, existential impact on the self, and the oracle. The participants' experiences were characterised by the relationship between themselves and their patients, the influence of working in palliative services on their world view, and the impact of organisational changes. Differences between working as a clinical psychologist in palliative care versus non-palliative settings were considered.

Conclusions: Professionals working in palliative care should be supported to reflect on their experiences of compassion and resilience, and services should provide resources that facilitate staff to practice positive self-care to maintain their well-being.

Key words: compassion, palliative care, psychologists, qualitative.

INTRODUCTION

Current national, European and World Health Organisation (WHO) guidelines for palliative services, including for adults with cancer, recommend the provision of psychological care (European Association of Palliative Care [EAPC], 2008; National Institute for Health & Clinical Excellence [NICE], 2004; NICE, 2011; Worldwide Palliative Care Alliance (WPCA) & WHO, 2014). As such, clinical psychologists are viewed as a vital part of palliative care teams across the world (American Psychological Association [APA], 2015; NICE, 2004; Payne & Haines, 2002; Price, Hotopf, Higginson et al., 2006). As well as engaging patients and families in intervention, clinical psychologists also conduct supervision, training, and consultation with professionals working in palliative care. Guidelines (British Psychological Society [BPS], 2008; NICE, 2004) have emphasised that healthcare professionals may require support to cope with the impact of their work, however the level of support required for clinical psychologists is currently unknown. Research concerning the experience of professionals working in palliative care has predominantly been conducted with nurses (Brown & Wood, 2009; King-Okoye & Arber, 2014; Mok & Chiu, 2004; Wilson & Kirshbaum 2011), with relatively few studies sampling clinical psychologists. The role of the clinical psychologist is to support many people within the systems worked in and to take care of themselves too. Other professionals often seek support form clinical psychologists when they experience difficult issues with patients, colleagues or within themselves. Therefore, it is important to consider who or what takes care of clinical psychologists, and what are the effects if this does not happen?

Psychological strategies can be utilised by professionals to protect themselves from the emotional impact of their work. The use of such strategies to regulate emotions can have a significant impact on health and well-being (Gross & John, 2003). For example, strategies such as expressive suppression (Gross & John, 2003), positioning oneself as an observer, and

having a task orientation can be employed to act as an emotional buffer (Armstrong & Rustin, 2015; Hopkinson, Hallett & Luker, 2005; King-Okoye & Arber, 2014; Menzies-Lyth, 1960; Wilson, 2014). However, creating an emotional distance in this way can hinder professionals' abilities to empathise with patients (Junger & Payne, 2011; Zapf, 2002). Compassion fatigue refers to a profound emotional and physical exhaustion felt by professionals in caring professions (Figley, 1995), which can lead to an erosion of empathy, hope, and compassion. Inversely, compassion satisfaction encompasses the positive aspects of helping those who experience trauma, such as the pleasure of providing care, being able to do it well, and beliefs about the self (Stamm, 1999). Many professionals in a caring role report experiencing compassion fatigue in varying degrees at some point in their career (Figley, 1995). Quantitative research indicates that the figure is between 40-85% (Mathieu, 2012). However, the prevalence of compassion fatigue, and related concepts such as burnout, distress, and secondary traumatic stress (Najjar, Davis, Beck-Coon et al., 2009), have been found to be inconsistent in professionals working in palliative care (Simon et al., 2005), with some research finding that compassion fatigue was actually lower (Sabo, 2008) or no higher in palliative care than in other areas of health (Pereira, Fonseca & Carvalho, 2011). It has been proposed that an accumulation of listening to patients' stories of suffering can lead to professionals experiencing compassion fatigue (Figley, 1995), and given that engaging with patients' distress is a large part of a clinical psychologist's role high levels of compassion fatigue could be expected.

A quantitative survey of clinical psychologists in Japan found that organisational pressures also contributed to experiences of compassion fatigue (Iwamitsu, Oba, Hirai et al., 2013). In addition, reduced face-to-face time with patients (Sabo, 2008) due to organisational changes, and an increase in demands and reduced resources (Flynn & Mercer, 2013; Lown, Rosen & Martilla, 2011; Mannion, 2014; Reeve, Lynch, Lloyd-Williams et al., 2012) have

also been suggested to be linked to reduced compassion. Compassion fatigue in professionals has been linked with increased absenteeism and staff turnover, as well as decreased productivity (Pfifferling & Giley, 2000). Considering cancer care specifically, a literature review (Shanafelt & Dyrbye, 2012) reported that work-related stress in oncologists presented as depression, anxiety, fatigue, and even suicidal ideation.

The issue of self-care amongst the caring professionals is not new with many emphasising its importance for several decades (Freudenberger, 1974; Guy, 2000; Kilburg, Nathan & Thoreson, 1986; Mahoney, 1997; Norcross, 2000; Saakvitne & Pearlman, 1996; Schwebel, Skorina & Schoener, 1991; Sussman, 1995). However, when other pressures are placed on professionals it is unclear whether they actually adhere to self-care practices. Bober and Regehr (2006) found that although participants in a sample of Canadian therapists believed several coping strategies would be useful in improving their well-being they did not devote time to practice these.

Research to date has largely excluded the exploration of experiences of clinical psychologists in palliative care, despite guidance (BPS, 2008; Junger & Payne, 2011; Kasl-Godley, King & Quill, 2014; NICE, 2004) suggesting that psychologists' roles in palliative care are likely to impact on their physical and mental health. It is unknown how clinical psychologists maintain their well-being despite working in services that potentially affect their ability to deliver effective care. The aim of this study was to explore the experiences of clinical psychologists working in palliative care services for adults with cancer, to gain an understanding of the impact of the work on their self and how they manage this.

METHOD

Design

A qualitative and reflexive approach was felt to be required to effectively explore the experiences of clinical psychologists in palliative care. It was felt that this would build upon previous quantitative research exploring experiences of professionals in palliative care (Najjar et al., 2009; Pereira et al., 2011; Sabo, 2011). Experiences were explored using semi-structured interviews and Interpretative Phenomenological Analysis (IPA) following the approach outlined by Smith, Flowers, and Larkin (2009), which was appropriate given the exploratory nature of the research and homogeneity of the participants.

Procedure

Recruitment and consent

Participants were recruited via a special interest group for psychologists working in oncology and palliative care, cancer network psychology groups, and ehospice internet group. Coordinators of groups forwarded a communication via their e-mailing list which introduced the project and attached a participant information sheet. A recruitment advert which gave details of the project and contact details of the researcher was placed in the United Kingdom (UK) edition of ehospice, a website publishing commentary on end-of-life care.

Participants

A purposive sampling method was used whereby clinical psychologists working in UK palliative care services were recruited. There are no set rules about the size of an IPA sample (Pietkiewicz & Smith, 2014). Given the aims of this project and the relatively small number of clinical psychologists working in palliative care in the UK this estimate was adequate to achieve theoretical sufficiency (Charmaz, 2006; Strauss & Corbin, 1990). A total of 23 professionals contacted the research team requesting to take part and they had all been working in palliative services for more than 12 months. Priority was granted to those who requested to take part first and met the recruitment criteria. The final sample comprised 12 clinical psychologists (3 males & 9 females), all of whom worked with adults with cancer as

part of their role in palliative care (Table 1). Participants had been qualified as clinical psychologists between 3 – 26 years, with the average length of time being 12.9 years and 50% of participants identified themselves as Consultant/Lead Clinical Psychologists. Data were anonymised to protect participants' identity.

INSERT TABLE 1 HERE

Data collection

Written consent was obtained from participants. Eight interviews were conducted and audio-recorded face-to-face at participants' workplaces, whilst four were conducted over the telephone. LC conducted all the interviews. Face-to-face interviews lasted between 49-71 minutes, whilst telephone interviews lasted between 51-71 minutes. In keeping with IPA, a topic guide was designed informed by existing international literature in compassion fatigue and satisfaction (Reid, Flowers & Larkin 2005; Stamm, 2012). The schedule used open questions to explore participants' experiences of working in palliative care. The areas discussed were felt to reflect issues relevant to psychologists working in palliative care internationally.

Data analysis

LC analysed data, with input from IF & CR. Interview transcripts were explored using IPA to extract initial themes around the experiences of participants within each interview transcript and then commonalities were identified across all the interview transcripts. These commonalities were explored and discussed by the research team to generate the final superordinate categories. IPA allowed for the detailed exploration of how participants make sense of and apply meaning to their personal experiences (Shaw, 2001). IPA attempts to capture the participants' outlook on the world, to gain, as much as is possible, an insider's view (Conrad, 1987). IPA also acknowledges and allows for the role of the researcher

interpreting experience through their own lens, therefore having an active and reflective role within the research (Smith, 2004).

Given the investigator's critical realist approach (Bhaskar, 1978) to research and the aim of this study being to explore the subjective experiences of clinical psychologists working in palliative care, IPA was deemed highly appropriate for the study. Critical realism proposes that whilst an objective truth may exist, individuals' subjective experiences are real and valid from their perspective (Willig, 2008). Given that individuals occupy and possess different positions and perceptions in the world, subjective differences ascribed to experiences and meaning are to be expected (Maxwell, 2012). A six-stage process was used to analyse data (Smith, Flowers & Larkin, 2009) and data saturation was achieved in the study.

Reflexivity

As recommended (Elliot, Fischer & Rennie, 1999), a brief statement regarding the researchers' positions are presented to acknowledge and bracket their stance in relation to this research. It is hoped that transparency about this will help readers to interpret the researchers' understanding of the data. LC and CR are clinical psychologists in a clinical health psychology department at a district general hospital, specialising in working with patients adjusting to physical health conditions. Both have experience of working with patients with cancer. IF is an experienced researcher and academic who has published extensive papers in oncology. To facilitate reflection and bracketing, and to enhance the credibility of the interviews and subsequent data analysis, the researcher used a field diary (Ortlipp, 2008; Smith, Jarman & Osborn, 1999). Criteria and guidelines for the standards of examining the quality (Elliot, Fischer & Rennie, 1999; Yardley, 2008) and reporting of qualitative research (Tong, Sainsbury & Craig, 2007) were utilised to ensure a high level of quality.

Ethics

The study was reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee, Lancaster University, UK.

RESULTS

Three superordinate themes were identified as being central to the clinical psychologists' experience of working in palliative care (Table 2).

INSERT TABLE 2

1) Commitment: "*More draining but also more rewarding*". (P12)

This theme captured what the clinical psychologists gained from working in palliative care settings but also what it cost them. Many of the participants described their experiences of working in palliative care positively, referring to it as "a privilege" (P5, P7, P11), whilst acknowledging that it felt "heavier but it doesn't feel hard" (P10). Several participants made comparisons between palliative care and mental health:

> *You can make a big difference very quickly… You get some of those real kind of buzzing moments I think in this job that there were maybe fewer of in community working in chronic long-term mental health conditions.* (P11).

Several participants stated that they worked with irreversible difficulties, including death, and as such were not expected to bring about change:

> *Knowing that I don't have to fix things for people, that isn't an expectation that that person has of me. They don't come in and go 'find me the miracle cure'… It's frustrating not to have the answers sometimes, but it's an absolute humbling honour to be able to sit and be with that person through that distress, to not try and fix it for them because that's not what they want you to do.* (P2).

As clinical psychologists their ways of working provided something different and valuable within a traditionally medical field that differentiated them from their medical colleagues:

> *The compassion that I feel isn't directed to sitting with people and commiserating with them necessarily or making everything better, it's about sitting with difficulties and allowing them to express those difficulties.* (P12).

It seemed that this gave the participants a sense of liberation, freed them from responsibility in a way, and somewhat set them apart from other professionals working within palliative care, adding to their sense of providing something different. There was uncertainty in the therapeutic relationship due to working with the threat of patient death, which led to an intensity and quickening of the therapeutic relationship, "That process is speeded up because you know you've only got six months." (P10). Patient death often led to abrupt therapeutic endings. Participants spoke about a sense of "unfinished business" (P4) and said, "it's hard to get a proper goodbye" (P2). The emotional aspect of processing patients' deaths often involved taking time to reflect upon and remember patients which provided closure for the clinical psychologists. However, it seemed that the frequency with which patients died meant the clinical psychologists had come to expect it, and had developed methods for processing these events that allowed them to move on relatively quickly:

> *I can't give too much time to kind of grieving because in a way it would stop you being able to do the job.* (P4).

Participants spoke of ever-present organisational changes due to economic climate, together with an aging population and increasing survivorships.

> *Many of us feel that pressure of trying to do more for less* (P2).

> *There's change afoot ... we know it's necessary, but it doesn't have a kind of firm shape to it yet.* (P11).

Several participants spoke about the demands that came with seniority forcing them into becoming more business-like and less compassionate:

> *You've got to be more disconnected from patient experience in a way, ironically because you are trying to improve patient services…it's probably all just a great defence mechanism.* (P6).

The increase on the demands of the clinical psychologists to do more with less often led to a personal striving to do well by their patients. There was a sense of clinical psychologists striving to do the very best that they could for their patients often with less resources. In doing so it is possible that their self-care practices were affected which could lead to a reduction in resilience:

> *There are some months where I get inundated with referrals, where I think I just can't keep going…I don't want to create a waiting list. I've avoided it so far but sometimes by giving up lunch breaks.* (P2).

However, most participants felt that organisational issues were the most stressful part of their role. There was a sense of clinical work being pure and strengthening:

> *Sometimes I can hide in the clinical work if some of the managerial tasks are a pain in the ass. I just book a few more patients and kind of strengthen me.* (P9).

The theme of 'commitment' was characterised by a balance of nourishment versus depletion that working with patients at the end of their life provides. The clinical psychologists felt it was a privilege and humbling to work in palliative care settings. However, this was countered by the clinical psychologists internalising a responsibility to meet the needs of the patients, whilst recognising that they could not 'fix' patients' situations but simply be alongside them during their experiences.

2) Existential impact on the self: "*You can't walk through water without getting wet*". (P4).

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This theme illustrated how the participants were affected and even changed because of their work. Several participants referred to the fact that everybody will die and therefore there was no distinction between patients and themselves. This seemed to make it easier to relate to patients by thinking, "You're just like me" (P8). Participants frequently referred to identifying with patients and a sense of "This could be me" (P8), that was different to working in other settings:

> "*I guess when you work in certain other settings you can really separate yourself off, it can be a real them and us type experience, … when I work in a palliative care service everyone's going to die and it's, you can't separate yourself off so easily from that".* (P3).

Participants described how they readily identified and empathised with patients:

> *You'll meet somebody that has an effect on you in a particular way and if that person's treatment isn't going to plan or they're getting bad news or you know eventually they die; you need to think about ways of keeping yourself well because there are moments where you can feel that kind of chest crushing sadness.* (P11).

Many participants spoke about the confrontation with death leading to them reprioritising their life:

> *I'm very fond of saying, that on their death bed nobody says I wish I spent more time at work, so that potentially is a way of getting your priorities straight.* (P1).

Several participants spoke about having an increased awareness of their own mortality that could not be restored:

> *A sharp reminder of how things can suddenly be fine one minute and next, you know, you could be in hospital for whatever reason and it, yeah, it definitely highlights how fragile humanity can be.* (P5).

In addition, participants gave accounts that inferred a sense of gratitude for life but also a lack of control: "It feels like there's no distance except randomness, on which chair I'm sitting, if I'm sitting on the patient chair or the clinicians chair". (P9).

Several participants also spoke about experiences that could be inferred as being representative of compassion fatigue. The impact of such experiences included not listening to patients, rumination, and insomnia. Whilst most of the participants spoke about these experiences, only four (P3, P4, P6, & P8) referred to "compassion fatigue" per se. There seemed to be an accumulative effect of hearing patients' stories around death that depleted the clinical psychologists' resources.

> *I was seeing a patient who was really really distressed ... I just didn't want to hear it, any more bad stuff. I just felt like I was full up with it and I didn't want to kind of hear about people's bad stories and miserable lives.* (P3).

Some of the experiences described seemed to have acted as defence mechanisms:

> *I would avoid a patient. So, I would go on the ward...I would see one patient instead of the other because I saw the one that I could manage, that emotionally I found less challenging. And the other, I would find ways of being busier and having very brief contacts with. Running away basically.* (P9).

The theme 'existential impact on the self' captured the impact of the work upon the clinical psychologists, including their growth and transformation. Although this work left them with a sense of fragility, overall it had positive effects on them, such as feeling an appreciation for life. The psychologists spoke of experiences of countertransference when dealing with multiple deaths and grief in their work. At times the psychologists had experiences that were reminiscent of compassion fatigue and they employed the use of defence mechanisms.

3) The oracle: "[The team] *see me as some kind of emotional robot who can kind of manage it all*". (P8).

This theme exemplified the clinical psychologists' expectations about a requirement to be the infallible expert on emotions and distress all the time, and the perceived expectations of others about how clinical psychologists should be able to remain emotionally detached from their work. The psychologists felt that their position in the multi-disciplinary team (MDT) meant that they were expected to contain the emotions of all others and be a source of support regarding all aspects of care:

> *That's often how psychologists get put into hospices because that's what they do in those places and in mental health teams and in many situations, psychologists, therapists, are able to hold on to levels of distress and anxiety and all kinds of difficult feelings well. (P7).*

Participants felt for the most part they managed this in a way that they believed was contained and an emotional response to their work however professional:

> *As a psychologist you get very well at managing your stuff in front of other people and containing your stuff. I think we have to but that doesn't mean we don't experience that stuff. (P4).*

Some participants felt they chose what to show others about how they felt, whilst they contained the rest of it:

> *I'd be really surprised if it was noticeable… at times I choose to say look this is what's going on inside my head rather than it being something that is hugely apparent to the outside world. (P7).*

Although participants described attempts at impression management at times this was difficult to maintain, and their feelings inadvertently leaked out:

It sort of was an acknowledgment to my manager and to my family that actually I

couldn't carry on doing what I was doing and something had to change. (P6).

Several participants spoke about feeling expected to act as a container for others' emotions

without any acknowledgement that they too could be affected.

There's this sort of expectation a bit, I think cos you're a psychologist, you'll be able

to deal with everything… of course it's much more difficult when you have your own

emotional reaction to things, you know I'm a human being too. (P8).

This seemed to be at odds with how participants actually felt with several acknowledging

sentiments like, "It's ok to find things upsetting…that's very much the sort of human element

of what we do." (P11). This sense of acceptance seemed to have developed over time for the

participants and was contrary to how some of them described initially feeling about their

emotional responses to work: shocked, embarrassed, and ashamed. It was also different to

how they imagined other colleagues felt about their responses.

Clinical psychologist off sick with exhaustion, depression, really? You know it was a

bit of an extra stigma…it's something that you know a lot about and therefore ergo

shouldn't suffer from but of course we're human, aren't we? (P6).

Learning about colleagues' experiences of compassion fatigue led to a normalisation and

acceptance of the impact their work could have upon them.

To see them go through that human experience and then to come through the other

side and be able to re-engage with work and do their job to the same level as before,

it's been a huge relief for me. (P9).

Participants commented on the importance of self-care and their ability as clinical

psychologists to heed their own advice.

For some it seemed that being a clinical psychologist meant by virtue that you should

"practice what you preach" (P5, P1, & P4). However, this was often suffixed with "or try

to", acknowledging that although the participants knew this in theory, in practice it was more difficult. Others described how it was not until they had experienced a period of not coping that they realised they did not practice self-care, and that this experience spurred them into acting.

> *You know generally on training people like talking away about self-care and you kind of think 'yeah, yeah, yeah, I know all that stuff' but actually being faced with the fact that I was feeling, literally I'm not sure if I can actually be a clinical psychologist anymore. That was a real wake up call for me.* (P3).

Methods of self-care included; eating well, exercise, time with family and friends, and personal use of psychological interventions. Work strategies encompassed; using supervision, monitoring their own emotional and physical responses, using grounding techniques, and turning off from patients' stories after sessions. However, potentially negative practices also occurred such as; not taking breaks, a reluctance to take annual leave, and regularly working over their hours. This seemed to be related to a sense of busyness and needing to fit more into their time at work. For some, the qualities of a clinical psychologist that makes them suitable for working in palliative care were an inner resilience combined with psychological knowledge regarding self-care methods. For others, it was about having an ability to reflect upon and acknowledge when self-care had slipped and being able to act on this. Although, for all participants the importance of self-care was apparent.

This final theme, 'the oracle', gave a sense that the clinical psychologists perceived that others expected them to always contain difficult situations and emotions, and at times they seemed to hold these views about themselves too. However, most psychologists acknowledged that this was a difficult feat and they also experienced natural emotions associated with providing care in a palliative setting. Some psychologists experienced periods that could be thought of as compassion fatigue.

DISCUSSION

Since the publication of documents (APA, 2015; BPS, 2008; EAPC, 2008; Kasl-Godley, King & Quill, 2014; NICE, 2004; WPCA & WHO, 2014) related to the provision of psychological care at the end-of-life internationally there has been relatively little research on the impact upon those delivering this, including clinical psychologists.

This study found that the clinical psychologists' experiences were characterised by the meaning they attributed to being part of palliative care, the nature of the therapeutic relationship, and the lasting impact of the work on the self. Several differences between working as a clinical psychologist in palliative care versus non-palliative settings were highlighted.

Whilst there were draining elements of the role, including a heavy emotional burden, as also noted in an exploration of nurses' experiences of working with people with cancer (King-Okoye, & Arber, 2014), it seemed that most participants felt the positives outweighed the negatives in a way that was unique to palliative care settings. These findings accord with Pereira et al's (2011) report that burnout in palliative care professionals is no higher than in other areas of healthcare and Vachon's (1995) finding that burnout is lower for palliative care professionals. It seemed that the clinical psychologists were able to engage with patients' emotion whilst remaining somewhat healthily detached. This was exemplified by them not feeling a pull to 'fix' patients' situations and to simply be alongside them through their experiences. It seemed that the process by which the therapeutic relationship between patient and clinical psychologist in palliative care developed was accelerated due to the sense of impending death and often led to abrupt therapeutic terminations. This provided a heightened intensity and intimacy in the relationship.

Participants felt that organisational issues had a negative effect on their levels of compassion and depleted their resilience, like clinical psychologists working in end-of-life care in Japan (Iwamitsu et al., 2013), whilst clinical work served to strengthen them. This links to suggestions that compassion within healthcare systems can be enhanced via organisational design (Crawford, Brown, Kvangarsnes et al., 2014; Vachon, 1998). Participants spoke of pressures on them and services, including an increased demand on services often with a lack of resources. There was a sense that an increased number of referrals with no such increase in resources led to a reduced quality of service for patients.

The research found that psychologists felt working in a palliative setting had an existential impact upon them which enriched their lives leading to growth and transformation, like the findings of Mok and Chiu (2004) with palliative care nurses. Most participants discussed an awareness of countertransference in their work. This included the ease at which they identified with, empathised with, and ultimately felt compassion towards palliative care patients. The feeling of 'this could be me' served to heighten their compassion. For most of the time the nature of patients' distress seemed to make it easier for the clinical psychologists to provide empathic support. Furthermore, this feeling of empathy was believed to strengthen participants' feelings of purpose and reward and add to levels of compassion satisfaction. These experiences contradict suggestions that individuals feeling higher levels of empathy are more likely to experience compassion fatigue (Figley, 2002). Alternatively, this may reflect the concept of 'exquisite empathy' which is defined as professionals demonstrating "highly present, sensitively attuned, well-boundaried, heartfelt empathic engagement" (p.213, Harrison & Westwood, 2009). As well as invigorating professionals, this connection with patients is thought to act as a protective factor against compassion fatigue (Mathieu, 2012).

Several participants spoke about a cumulative effect of listening to patients' stories leading to a feeling of depletion similar to that described by Figley (1995) and Vachon (2006). When working in a palliative care setting participants regularly experienced death and were confronted with the fragility of life. Some participants spoke about tuning out to patients' distress or even avoiding patients altogether. In this sense, the participants were similar to professionals in previous research who were found to employ such strategies to create distance between themselves and patients' experiences (Hopkinson, Hallett & Luker, 2005; Junger & Payne, 2011; King-Okoye, & Arber, 2014; Menzies-Lyth, 1960).

Some participants described becoming hardened to the impact of their work and feeling that this was maladaptive. Previous research has suggested that this can create an emotional dissonance for professionals which can contribute to a negative effect upon levels of resilience (Kovacs, Kovacs & Hegedus, 2010; Tardy & Dindia, 2006; Zapf, 2002). Two main approaches were present; reporting having experienced compassion fatigue or experiences that could be compassion fatigue, or continually being able to manage. Experiences that could be thought of as compassion fatigue initially evoked feelings of shock, shame, and embarrassment. However, all participants felt that compassion fatigue was an acceptable experience, something to monitor for, and that they could act to decrease the effects via self-care. Participants' experiences of compassion satisfaction were also apparent, including the pleasure of helping patients, being able to do their role well, and feeling valued in the workplace. Self-compassion was evoked by acknowledging the impact of their work and engaging in self-care to build and maintain resilience.

In considering Gross and John's (2003) theory of emotion regulation, it seems the participants used strategies of response modulation to modify their emotion-related actions but did not seem to require the use of cognitive change strategies. In other words, the participants appeared to accept the sadness of their work without the need to change this and responded in

ways that did not intensify their sadness. This is in comparison to research with other professional groups who reported it was difficult to manage their emotions in palliative settings (King-Okoye, & Arber, 2014).

The participants felt that others, and sometimes themselves, held perceptions about their ability to contain emotions. These perceptions often led to a sense that they should not feel a particular way about issues and they certainly should not show it at work, similar to research with palliative care nurses (Feldstein & Gemma, 1995), and in varying degrees these effects resonated with compassion fatigue. However, most participants spoke of a balance between demonstrating an expected level of emotional competence whereby their emotions and those of others were contained, versus acknowledging the very human side of working with people at the end of their life.

Clinical psychologists recognised the importance of engaging in self-care and used a range of coping strategies to build and maintain resilience, which included mindfulness, supervision, maintaining physical health (Kearney, Weininger, Vachon et al., 2009; Pearlman, 1999; Swetz, Harrington, Matsuyama et al., 2009) and using peer support (Catherall, 1999). The importance of clinical supervision to help and protect professionals when working with cancer, dying and bereavement has been emphasised previously (Jones, 2000).

Future research

Given the importance of the therapeutic relationship for participants, investigating which facets of the relationship are potentially most protective and how this contributes to experiences of work, as well as impacts upon professionals and patients will be beneficial. The impact of organisational changes warrant further investigation from both patients and health professionals' perspectives, to determine how best to buffer potentially negative change.

Strengths and limitations

The study researched an area which has received relatively little coverage to date, and in which more detailed research is needed. Previous research has been related to other palliative care professionals rather than clinical psychologists. Understanding clinical psychologists is valuable given that they are often supporting other healthcare professionals working in palliative care services, including cancer. This study shed light on the experiences of clinical psychologists as a group of professionals who are usually the listeners and containers rather than the talkers. It is important to note that the cohort of clinical psychologists in this study had a varied level of experience, with years qualified ranging between 3 – 26 years, with an average of 12.9 years, rather than a relatively inexperienced group. Rather than the experiences of compassion fatigue discussed by the participants being due to a lack of experience or inadequate training in palliative settings, there are several factors that may impact upon the participants' experiences. For example, participants spoke of their level of seniority increasing their involvement in service development and organisational issues, which then increased the demands and pressure they faced. In addition, the health service in the UK is currently under extreme pressure including a lack of resources reducing capacity despite an increased demand. This leads to pressures on services and professionals, which may impact experiences of compassion fatigue. Finally, experiences of compassion fatigue may be due to individual characteristics and differences not accounted for in this study, but common across this cohort.

The use of IPA to explore the experiences of clinical psychologists allowed the participants' stories to be heard without the inflexibility of pre-determined hypotheses. In discussing experiences of compassion fatigue, the participants demonstrated their high levels of self-awareness, in their ability to be aware of and reflect on their own experiences and feelings and recognise how this affected them. Furthermore, the participants' openness

reflected the rapport established during interviews which may have been enhanced by the interviews being conducted by an individual training to be a clinical psychologist and thereby within the same profession as them.

A limitation of the study, given that all the participants were still working in palliative care settings, is that those most severely affected by the impact of their work may have chosen to leave the area already. Furthermore, the participants were self-selecting and potentially chose to take part in the study because they felt they had positive self-care practices that they wanted to share. In addition, the participants that took part in the study may have considered themselves as having the time to reflect on their practice and perhaps those that were experiencing compassion fatigue felt they were too busy and did not take part.

It is possible that there may be differences in experiences between clinical psychologists working in palliative care as opposed to those working with individuals engaging in curative treatment, given that in the latter setting perhaps patients were not expected to die, compared to clinical psychologists working with patients where it is apparent that their condition is palliative. A further possible methodological limitation of the study is the potential differences resulting between face to face and telephone-based data collection. Due to time constraints and convenience for participants, some interviews were conducted over the telephone. Telephone interviews have been suggested to be able to provide data that is as equally valuable as face-to-face interviews (Carr & Worth, 2001; Sweet, 2002). Increasingly researchers are suggesting that with improvements in technology, data collection no longer needs to rely only on face-to-face interviews (Carr & Worth, 2001). The four telephone interviews in this study were on average two and a half minutes shorter than the eight face-to-face interviews. However, caution has been advised when drawing conclusions about the quality of data based on the length of interview time (Irvine, 2010). It has been suggested that whilst telephone interviews result in a loss of non-verbal cues, ideas that this

results in difficulties in rapport and communication have been made despite there being a lack of evidence regarding telephone interviews (Irvine, 2010; Novick, 2008). Alternatively, it has been suggested that telephone interviews could involve a different type of interaction but not necessarily result in disadvantage for research (Irvine, 2010). Further research is needed to establish an evidence base regarding the advantages and disadvantages of using telephone interviews, as well as other technological communication methods, in qualitative research (Irvine, 2010; Novick, 2008).

Clinical and theoretical implications

The importance of psychosocial care within the palliative MDT is clear (Fan, Lin, Hsieh & Change, 2017). The findings of this research shed light on the experiences of clinical psychologists working in palliative care, as well as methods to cope with the impact of their work upon themselves, so that they remain resilient and provide effective services to patients, families, and colleagues alike. This may have training implications for clinical psychologists wishing to pursue a career in this field, due to its difference from more traditional roles within mental health (Payne & Haines, 2002). Guidelines have made several suggestions for the training of palliative care psychologists, including reflecting on the impact of work, the containing of emotions, and the ability to recognise ones' own limitations (Junger & Payne, 2011). In addition, creating systems to encourage more practitioners to identify, discuss, and seek support around experiences of compassion fatigue may enhance resilience and help to normalise and reduce stigma attached to these experiences. One such intervention that is gaining momentum internationally are Schwartz Rounds (Schwartz Centre for Compassionate Healthcare, 2011). Schwartz Rounds aim to provide a structured forum where professionals in an organisation regularly meet to discuss the emotional aspects of working in healthcare to increase compassion in such services both for patients and professionals (Point of Care Foundation, 2016).

Conclusions

The study highlighted the experiences of clinical psychologists in palliative care and factors that contribute to their ability to provide effective care in this area. Participants' experiences were characterised by a balance of potentially depleting and nourishing aspects of the role, the lasting existential impact on the self, and a propensity to be seen to be a consummate professional at all times. The participants felt that self-care was particularly important in ensuring their ability to have a sustainable career in this field.

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Table 1: Participants gender and therapeutic contact with palliative care patients.

Participant	Patients
P1 male	Palliative care patients with cancer and chronic obstructive pulmonary disease (COPD).
P2 male	Palliative care patients with cancer.
P3 female	Palliative care patients with cancer and other palliative conditions.
P4 male	Palliative care patients with cancer and other palliative conditions.
P5 female	Palliative care patients with cancer and other palliative conditions.
P6 female	Palliative care patients with cancer and other palliative conditions.
P7 female	Palliative care patients with cancer and other palliative conditions.
P8 female	Palliative care patients with cancer and other palliative conditions.
P9 male	Palliative care patients with cancer.
P10 female	Palliative care patients with cancer.
P11 female	Palliative care patients with cancer.
P12 female	Palliative care patients with cancer.

Table 2: Superordinate and sub-themes identified in the analysis.

Themes	Sub-themes
1) Commitment: "*More draining but also more rewarding*".	Costs versus gains of working in palliative care Not having to 'fix' situations Providing something different as a professional in palliative care The therapeutic relationship Organisational changes The pressure of trying to do more for less
2) Existential impact on the self: "*You can't walk through water without getting wet*".	Personal changes because of the work Identifying with patients Confronting own mortality Compassion fatigue Protective strategies
3) The Oracle: "[The team] *see me as some kind of emotional robot who can kind of manage it all*".	The consummate professional Perceived expectations of others Containing emotions Feeling human Self-care Practice what you preach