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Compassion fatigue and global compassion fatigue in practitioner psychologists: a qualitative study

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Abstract
Practitioner psychologists are at risk of compassion fatigue (CF) due to the emotional demands of helping individuals who have experienced pain and suffering. Practitioner psychologists may also be impacted by wider socio-political events (such as the COVID-19 pandemic), which can lead to global compassion fatigue (GCF). While these concepts have been examined in various healthcare professionals, research exploring the impact of CF and GCF on practitioner psychologists has been very limited. This study therefore aimed to explore the impact of compassion fatigue (CF) and global compassion fatigue (GCF) on practitioner psychologists' practice. Ten participants were recruited for online semi-structured interviews during the height of the COVID-19 pandemic. Data collected was thematically analysed. Five themes related to compassionate care were identified, which included: 'How to be compassionate', 'Psychologists require TLC too!', 'Hindrances of compassionate care', 'Constraints within the NHS' and 'Indicators of compassion fatigue and burnout'. Three themes related to GCF were identified, which included: 'Effects of news/social media', 'Management of news/social media' and 'Challenges faced by COVID-19'. The implications of CF and GCF and ways to mitigate their effects on practitioner psychologists' wellbeing, development, and their practice are discussed.

Keywords Compassion fatigue · Qualitative · Practitioner psychologist · COVID-19

Introduction

Compassion fatigue (CF) refers to an emotional or physical stress response that occurs from a gradual depletion of empathy or the ability to nurture others (Adams et al., 2006). Within the literature, it has been acknowledged as a prevalent factor that is capable of diminishing one's own health and well-being (Sabo, 2011). This specifically extends to healthcare providers' ability to respond compassionately towards their patients (Cavanagh et al., 2019). According to Berzoff and Kita (2010), CF can arise as a result of "a cumulative experience of caring for people who are suffering, and the personal experience of the persistent excess of suffering despite one's best efforts at ameliorating it" (p. 343). It is therefore vital that practitioners remain impartial while also empathetic throughout their clinical practice. This enables a practitioner to protect themselves from distress, while meeting the emotional demands and support needed by patients (Berzoff & Kita, 2010). Whilst the majority of research seems to have addressed the importance of compassionate care across a diversity of disciplines, it is not something that is routinely assessed in a psychologist's role (Rodriguez & Lown, 2019).

Previous research has demonstrated a multitude of factors that can increase a healthcare professional's (HCPs) susceptibility towards the effects of CF. For instance, practitioners who have experienced personal trauma in their past or lack support networks are at higher risk of CF (Martin-Cuellar et al., 2019). There are also lifestyle factors such as the inability to incorporate healthy, self-care strategies alongside the usual work routine and poor stress management (Ireland & Huxley, 2018). On the contrary, the effects of compassion satisfaction (CS) can be elevated through effective self-care mechanisms, a supportive work environment and accessibility of sufficient resources to deal with stress, as well as an optimistic outlook towards client interactions (Cuartero & Campos-Vidal, 2018). CS refers to the positive attributes

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and feelings experienced as a result of making a difference to the welfare of others (Hooper et al., 2010). Stamm (1995) emphasised that a prominent method to alleviate the negative impacts of CF and burnout, as well as to accentuate the commitment and motivation among HCPs towards their profession, would be to focus on improving CS. Due to the nature of practitioner psychologists' role, it is possible that this population remain at higher risk for experiencing CF. Psychologists strive to help others with an expectation that they will do so from a stance of unwavering empathy. Moreover, practitioner psychologists are frequently exposed to their patients' or clients' suffering, which particularly puts them at great risk for experiencing CF (Harling et al., 2020). A meta-analysis by Cavanagh et al. (2019) recognised that the consequences of CF on healthcare professionals are detrimental to their wellbeing, professional practice and the workforce.

Singh et al. (2018) comprehensively explored the perceived barriers and facilitators of compassionate care from the direct perspective of HCPs. Singh et al. (2018) outlined several factors that enabled practitioners to provide compassionate care, such as personal, relational and systematic facilitators. This study also identified several factors that challenged a practitioners' ability to be compassionate as a result of personal, relational and systematic obstacles; many of which were able to be circumvented depending on the responses to these challenges. In order to evaluate the potential impacts of CF, it is important to acknowledge a practitioners' perspective towards compassionate care and how it applies to their specific profession. Research has shown that psychologists experience similar challenges. Harling et al. (2020) explored the experiences of CF in Swedish psychologists and identified key organisational, protective and contributing factors. These included organisational challenges such as high workloads and reduced autonomy in the work role. Protective factors included engaging in self-care and continuing professional development activities, and being in control of their work environment.

'Vicarious traumatisation' (VT), a related concept to CF, refers to the cumulative and adverse effects that can occur in therapists through exposure to their patient's experience of trauma (McCann & Pearlman, 1990). Similarily, Robino (2019) constructed the term 'global compassion fatigue' (GCF) to explain "the process by which an individual experiences extreme preoccupation and tension as a result of concern for those affected by global events without direct exposure to their traumas through clinical intervention" (p. 274). Although GCF may be related to CF, its effects can be experienced indirectly and present a greater challenge to HCPs on a larger scale (Robino, 2019). Whilst research on the potential effects of GCF on practitioner psychologists and their clinical work is scarce, there is evidence to suggest it can have negative consequences on individuals' lives and the ability to continue with professional duties (Gustafsson & Hemberg, 2021). Moreover, advances in technology has made news of global event much more accessible with an increase in SM use from 44 to 49% among adults since 2018 (Ofcom, 2019). This indicates that regular engagement with SM leads to a greater probability of exposure to reports of distressing news content (Robino, 2019), which can in turn increase the risk of GCF. Therefore, this indicates that the role of the media can have detrimental implications for those that are not directly involved in a tragic event, including HCPs.

The COVID-19 pandemic has been an unprecedented global event that has led to various socio-political challenges. Its extensive media coverage has posed a significant risk of heightened psychological distress that could exacerbate the effects of GCF among mental health professionals (Shah et al., 2020). Research is limited in exploring the effects of GCF among mental health professionals and the role of SM in exacerbating its impact on wellbeing (Robino, 2019). More specifically, the COVID-19 pandemic has provided a rare context in which to explore the effects of GCF in mental health professionals.

This current study aimed to explore CF and GCF among private sector psychologists in the United Kingdom (UK). CF was explored using questions on compassionate care that were adopted from Singh et al. (2018). GCF was explored by asking practitioners about their news source consumption and SM usage, as well as their experiences of indirect exposure to tragic global events. The experiences and impact of both CF and GCF on clinical practice were explored in detail to gain an in-depth understanding of their effects on the participants.

Method

Study Design

Semi-structured interviews were conducted as part of the data collection for this study to enable participants to contextualise topics and issues in more detail, while allowing considerable flexibility towards the exploration of themes (Robson, 2002). Both structured questions and unstructured follow-up questions were formulated to elicit a more nuanced understanding of the potential effects of CF and GCF (see Supplementary Material 1). The questions in the interview guide (see Appendix A) were selected and/or adapted from Singh et al. (2018), due to the overlap in the study design and focus on CF. The interview schedule questions that focused on GCF aimed to explore news source consumption and SM usage, as well as the impact

of exposure to suffering on a global or national scale on the ability to continue providing compassionate care. The study was approved by the University of Portsmouth's Psychology Department's ethics committee.

Recruitment

Participants were recruited using a purposive sampling method. To be eligible, participants had to be employed as a psychologist within the private sector at the time, as well as recognised as having Health and Care Professions Council (HCPC) registered status. They were located through either the British Psychological Society (BPS) Directory of Chartered Psychologists or professional networking accounts such as LinkedIn. A total of 103 registered psychologists were emailed the invitation to the study.

For this study, the sample was intended to range between eight (minimum) to ten (maximum) participants. According to Bernard (2012), the appropriate number of interviews required in qualitative research depends on as many it takes to reach data saturation, yet this can be quite challenging to measure. Therefore, to increase our confidence that we have reached data saturation, we sought to maximise the depth of each interview and comprehensively code, analyse and interpret insights from our sample to result in rich data (Schultze & Avital, 2011).

Participants

A total of ten participants were recruited. All participants identified as White British, with their ages ranging between 41 and 63 years old. All participants were employed in the private sector at the time of each scheduled interview, with many who also had previous experience within the public sector. Full demographic information is shown in Table 1.

Procedure

Those considered eligible received an invitation email, which outlined the study purpose and expectations and why they were approached. Those interested in participating or seeking further information were able to respond to this email with their interest and were sent a participant information sheet, a consent form and a demographics questionnaire sheet. They were asked to read, sign, and return these forms by email. Consenting participants were able to retain their own copies of the documents.

All interviews took place online using video-conferencing systems and took place during a time that was convenient for participants. Eight of these interviews were held over Skype, while the other two interviews were held over WebEx. They were audio/video-recorded for the purposes of verbatim transcription and data analysis. The length of the interviews ranged between 33 and 77 min (Mean = 51.6 min; SD = 12.87). On the day of each scheduled interview, the researcher reiterated the main aims of the study and confirmed that the participant gave their consent to take part. All participants were given the opportunity to have any queries answered satisfactorily prior to the interview commencing. At the end, participants were thanked for partaking.

Data Analysis

For this research, thematic analysis (TA) was chosen to identify and interpret common themes across the participants interviews (Braun & Clarke, 2006). TA is a flexible approach and can be applied to various sample sizes and data collection approaches (Braun & Clarke, 2013). The analysis was inductive and not based on any pre-existing coding frame. The analyses followed the steps outlined in Braun and Clarke (2013). This first involved familiarisation with the data and coding. To achieve this, transcripts were read and re-read several times. All interview transcripts were coded to capture the trends amongst the data. Codes were defined as sections of the data that had significant

Table 1 Participant demographic information

Participant number	Age	Gender	Occupation Title	Length of time working as a practicing psychologist (in years)	Length of time employed in the NHS (in years)
P1	63	Female	Counselling Psychologist	14	0
P2	58	Female	Health Psychologist	8	6
P3	41	Male	Counselling Psychologist	5	3
P4	61	Male	Clinical Psychologist	33	8
P5	54	Female	Clinical Psychologist	28	26
P6	53	Female	Counselling Psychologist	6	0
P7	57	Female	Clinical Psychologist	25	22
P8	42	Female	Clinical Psychologist	11	11
P9	47	Female	Clinical Psychologist	24	22
P10	42	Female	Clinical Psychologist	16	8

meaning in relation to our research aim (Braun & Clarke, 2013). Patterns across the data were explored and the codes were grouped into themes. The initial themes were then refined several times until distinctive and coherent themes were identified and agreed upon by KS and MAA.

Assessing validity

Yardley's (2000) principles to assessing validity in qualitative studies was followed to ensure the quality and integrity of the study was upheld. The first principle was 'Sensitivity to context', which was addressed by ensuring an awareness of the relevant literature and the context of the ongoing pandemic. The second principle was 'Commitment and rigor', which was addressed through diligence towards reading, analysis, and interpretation involved in TA to construct major and minor themes from the data. The third principle was 'Transparency and coherence', which was achieved through the thorough documentation of each step of TA, including data collection, analysis and interpretation and its relevance and application towards existing literature. The final principle was 'Impact and importance', which was followed through the exploration of the potential impact of CF and GCF on practising psychologists. The findings provide a rich insight into this under-researched and novel area of psychological practice and is of significant importance.

Reflexivity

The research topic became a personal interest to KS as a placement student working alongside practitioner psychologists. After discussions with fellow colleagues and searching the literature, KS became aware of the issues surrounding emotional neglect patients sometimes face in healthcare. This motivated KS to investigate these occurrences from a practitioner's perspective, and the possible explanations for diminished compassion or empathy towards a client (i.e., CF). Further research led to the discovery of GCF, which led to the realisation of its relevance to the COVID-19 pandemic. Overall, these unprecedented circumstances meant the study took place against the backdrop of the pandemic, which meant participants and ourselves as researchers would have likely experienced a heightened awareness of the consequences of CF and GCF. Conducting this study during the context of the pandemic would have shaped our personal experiences, views, and research process.

Results

The analysis was divided into two parts, namely (i) themes in compassionate care and (ii) themes in global compassion fatigue. The subsequent analysis led to a total of eight overarching themes and 21 subordinate themes. These themes were reflective of the participants' experiences and encapsulated something salient about the data in relation to the research aims (Braun & Clarke, 2006).

Part one: themes in compassionate care

There were a total of five overarching themes and 11 subordinate themes (see Fig. 1). The major themes included the following: 'How to be compassionate', 'Psychologists require TLC too!', 'Hindrances of compassionate care', 'Constraints within the NHS' and 'Indicators of compassion fatigue and burnout'. Table 2 summarises the major themes and subthemes with associated quotes.

How to be compassionate

This overarching theme explores the practitioners' perspectives on what compassionate care means to them and the approaches they use to work sensitively with their clients/patients.

Understanding and empathetic stance

Participants highlighted the significance of empathy in being compassionate. This was described as working very closely with client/patients and immersing themselves in what they are saying, before presenting the narratives back in a thoughtful manner. For example:

> Compassionate care to me is being able to be alongside somebody when you're working with them in your clinical experience, to be able to absorb what they're talking to you about, to be able to reflect it back, but with kindness, caring and full attention. (P7, 57, Clinical Psychologist)

Many participants indicated that compassionate care relies on a clinician's motivation towards being open-minded and attentive to a client's needs. Compassion depends on the collaborative efforts of both the clinician and client, as well as them working together very closely. It was highlighted that a key element in maintaining a comprehensive understanding of a client's needs is to listen to them carefully and thoughtfully. This could be demonstrated to a client by relaying what they were told during a session to clarify their individual experiences, as well as showing genuine interest in alleviating their distress.

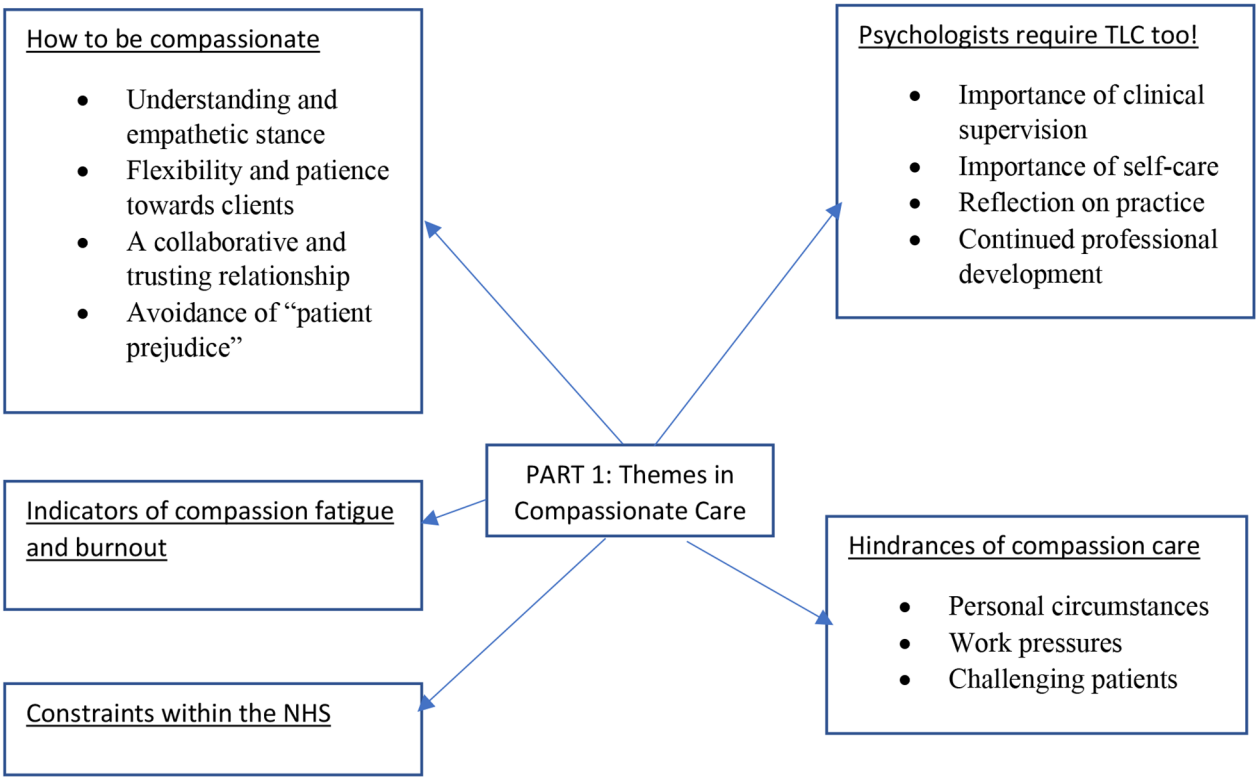

Fig. 1 Thematic map of major and subordinate themes in compassionate care

Flexibility and patience towards clients

Participants expressed a need for flexibility and patience in their approach towards offering compassionate care. For example, participants stated that a structured therapeutic model or theory may not necessarily be appropriate or practical given the complexities of the problems individual clients may be experiencing. Therefore, any care offered to patients should be individualised.

> Trying to individualise care for them as well so that it's not just about sort of applying a textbook model or theory to the person. But trying to really think about all the different sort of factors influencing what the person is presenting with and what their needs are. (P8, 42, Clinical Psychologist)

Additional ways participants have had to be flexible included arranging additional therapy sessions or shifting the application of usual protocols for their clients. For many participants, it was important to pace sessions flexibly according to their clients' needs as it to build a strong therapeutic alliance, which in turn would provide the space to them to progress.

A collaborative and trusting relationship

This sub-theme denotes the importance of maintaining a meaningful bond as part of the practitioner-patient relationship. Some participants expressed the importance of the trust clients' have in their HCP as an important foundation before being motivated to engage in sessions.

> She trusted me, and because I got to know her and got to know so much of her as a person, not just about the trauma but all the other stuff that made up who she was. I was able in those moments to offer her what she needed to help her continue feeling safe, even when we were working with the most painful stuff that made her very frightened. (P8, 42, Clinical Psychologist)

Participant 8 suggested that taking time to understand a specific client's experience of trauma meant that she was able to provide a 'safe' space, which was vital when painful experiences were revisited.

Avoidance of "Patient Prejudice"

A number of the participants expressed the importance of being aware of any pre-conceived notions they have about their clients and to avoid holding on to these too tightly. Instead, the importance of stripping power imbalances to

Table 2 Summary of major themes and sub-themes in compassionate care

Major theme	Sub-theme	Participant quote
How to be compassionate	Understanding and empathetic stance	*I think compassionate care is being able to be kind of focused and committed, and empathic with the person sat in front of you. (P10)*
	Flexibility and patience towards clients	*You have to remember that not everybody can do this, this and this. You know, some people don't have the education, or the life experiences, or the mental space to kind of just sit back and think about things calmly.(P1)*
	A collaborative and trusting relationship	*The more that you can engage and connect with that person, the better you are at delivering compassionate care.(P10)*
	Avoidance of "patient prejudice"	*I think early on in my career I learnt not to judge, not to make assumptions the first time I met someone. (P7)*
Psychologists require TLC too!	Importance of clinical supervision	*'So I guess sometimes if it can help change perspective, so it can help you to consider the person's difficulties, or how they're presenting from a different perspective. I think that's the value of clinical supervision'. (P9)*
	Importance of self-care	*'For me, I was aware I needed a break and that I couldn't – I was full. I felt like being a sponge that was full. I couldn't, you know, could no longer offer what I needed to be able to offer which was when I would always take a break, and take on some extra self-care'.(P7)*
	Reflection on practice	*I'm also aware that it's also picking a risk for me 'cos I have to dig within and open up something that's…it takes something out of me. (P6)*
	Continued professional development	*I mean obviously CPD is really important to keep your practice… It's really important to keep that going throughout once you're qualified. But also it's like I say working in private practice where I'm pretty much on my own it's really – it's been a really helpful way of connecting with other professionals.(P8)*
Hindrances of compassionate care	Personal circumstances	*I think you need your own strength and your own – you need to be coming from a secure place yourself to best offer compassionate care. (P9)*
	Work pressures	*And I think it's harder possibly for staff that have been in services longer, who came in with the belief that that was part of their role. And roles have changed and there's not so much time for that compassionate side. (P7)*
	Challenging patients	*Sometimes clients have been very challenging, it's harder when someone is very angry with you to reach that place when you can be compassionate.(P6)*
Constraints within the NHS	-	*I've had limited experience of that since leaving the health service. In the health service that was a major part of the job- the frustration, because of the various constraints and conflicting models of care. It's exhausting because you couldn't provide a proper service to people, and that was the product of the structure. The organisation trying to fit psychological models in with psychiatric models and beliefs.(P4)*
Indicators of compassion fatigue and burnout	-	*'That's stress and burnout, and we see it all the time. People go off sick, they may make mistakes, but generally it can lead to depression and anxiety. Yeah, and burnout. And I think we do see that a lot in other health professionals because the demands are such that they cannot provide that'.(P7)*

avoid disconnecting from clients was highlighted. Participants highlighted the importance of promoting an equal relationship dynamic that is characterised by openness and acceptance. Moreover, For example, participants reflected that if a client believes that their psychologist holds critical presumptions or judgements, it could lead to reduced engagement or absence during sessions. This notion is reinforced by the extract below:

There's a risk of alienation from your clients, from seeing yourself as different to them, separate rather than human beings with shared experience. So it would stop you at best getting alongside them, at worst being critical. A critical person next to them. (P7, 57, Clinical Psychologist)

Psychologists require TLC too!

This overarching theme explores the difficulties with work-related stress practitioner psychologists face as part of their role. Participants shared the number of coping strategies they use to help them deal with the challenges and emotional demands of their role.

Importance of Clinical Supervision

Many psychologists spoke about the importance of clinical supervision as valuable opportunity to overcome any barriers, frustrations or concerns faced throughout practice. A significant part of a practitioner psychologists' role includes supporting and fulfilling the emotional demands required of their clients, whilst remaining not too emotionally invested. This balance was a challenge for some participants and can be emotionally taxing. Supervision provides an outlet in which to discuss such challenges. In addition, participants shared the value of supervision in that it provided them the space to reflect on their practice and listen to a different perspective on the way their client may be presenting. For some participants, this helped them renew their sense of compassion towards their clients:

I've had lots of experiences with one of my clinical supervisors where her kind of helping me to understand something about where somebody was coming from, there's a sense of the compassion being restored. (P5, 54, Clinical Psychologist)

Importance of self-care

This sub-theme illustrates the importance of self-care among clinicians and maintaining this outside of practice through restorative activities. Neglecting one's own mental and physical health was suggested to prevent the ability to provide compassionate support in the long term: "I think it's more difficult to maintain compassion if you're tired, or burnt out, or overloaded, or stressed by other things." (P5, 54, Clinical Psychologist). Some participants reflected on their experience of feeling more 'fatigued' over time and the negative impact this had on their practice. To be able to support clients in the long run and provide the support they needed, participants expressed that they would try and ensure they give themselves dedicated time and space to relax or take a break to decompress.:

Sometimes, you know, over time the fatigue builds. So I think for me, the way to deal with that is really to have space to myself, have some time to just chill. (P6, 53, Counselling Psychologist)

Reflection on practice

This sub-theme explores participants' perspectives on utilising reflective practice to overcome the challenges associated with maintaining compassion in their work in the long term. Some participants acknowledged that whilst clinicians uphold a duty of care for their clients, they are also vulnerable to occasional errors in judgement. In order to offer the best quality service of care to clients, Participant 4 reiterated the importance of reflective practice to improve clinical practice. For a number of participants, reflective practice involves monitoring one's own well-being and self-care regime, being open to supervision, being able to access a support network in psychology and other relevant resources.

You got to be open enough to monitor oneself and there are supervision arrangements, an on-going access to other people's opinions, and views, and information, and literacy—you're constantly just reflecting on it really. It's an active process to partly self-care, but it's primarily making sure you're offering the best quality service that you can. So that's the responsibility of the job. (P4, 61, Clinical Psychologist)

Continued Professional Development (CPD)

Participants spoke about the importance of CPD to enable them to continue to provide a high level of care whilst also connecting with other professionals. For participants, this also enabled them to continuously build upon their knowledge and increase self-awareness. For some participants, CPD provided an opportunity to connect with other psychologists and build their professional network. CPD allows psychologists to offload the challenges that come with maintaining compassion and a chance to share experiences and strategies with other psychologists working in similar fields. This is particularly vital as working in the private sector is isolating for some participants:

It's really important to keep [CPD] that going throughout once you're qualified. But also, it's like I say working in private practice where I'm pretty much on my own it's really – it's been a really helpful way of connecting with other professionals. (P8, 42, Clinical Psychologist)

Some participants also highlighted the need for more CPD opportunities with a specific focus on improving and supporting compassion in psychological interventions in the longer term. This is to address the fact that it may not be sustainable to have the same level of compassion year after year.

Hindrances of compassionate care

This overarching theme explores the different factors that made it difficult for participants to provide and maintain compassionate care towards clients. For many participants this ranged from factors that were more personal as well as work related.

Personal circumstances

For participants, the impact of personal circumstances can have a profound effect on the ability to provide compassionate care, especially if their personal issues or problems leak into their work life. If this occurs, participants reported finding it difficult to effectively cope with managing their practice when they feel stressed or preoccupied with life events. Participants shared that this is because providing compassionate support to their clients relies on significant psychological and emotional resources, which may not be available if they are drained from personal circumstances. This in turn can potentially decrease the quality of care offered to clients. This is highlighted by Participant 10 below:

I think your own personal circumstances, you know. That requires you to put energy into the other individual, and kind of be able to focus. So if you've got other things that are draining your own resources then it's really difficult

to actually re-enact resources and energy for another individual. (P10, 42, Clinical Psychologist)

Work pressures

A number of participants reflected on how pressures at work such as poor managerial support, constant structural changes of an organisation, and its reduced quality of provisions impacted on the quality of care they were able to provide to their clients. More specifically, participants reflected on how systemic work challenges reduced their motivation and sense of compassion as a result of not feeling valued. Many participants believed that they should be supported by the organisation itself, and by their supervisors and colleagues to alleviate the stress experienced at work so that their duties can be executed effectively. These ideas are supported by the extract below:

I think the structures of the organisation that you work in have a big impact on how possible it is to deliver compassionate care and that, you know, if the organisation has values around that then it's easier to do that. But if the organisation doesn't, then it becomes more difficult to work compassionately. (P 5, 54, Clinical Psychologist)

Challenging patients

This sub-theme encapsulates the participants' experiences with challenging patients and the impact on their ability to maintain compassionate. Some participants referred to these individuals as "heartsink patients" who overtime deplete their resources for providing compassionate care to them. These types of patients were described as having interpersonal difficulties with significant distress, and who tend to progress very little between sessions. Supporting such patients was described as exhausting and draining, which would likely lead to experiences of CF:

So sometimes you would have what you would refer to as heartsink patients. So people who were known amongst the whole team as quite challenging to be in a room with, who would often have interpersonal difficulties, who were very distressed – so they'd have distressing backgrounds. And who wouldn't make a lot of progress from session to session. And the whole session you knew before you even got in there would be very tiring, challenging, exhausting, and emotionally draining. (P9, 47, Clinical Psychologist)

Such experiences can weaken the foundations of the therapeutic alliance. In some instances, participants have reported difficulties in being able to improve their clients progress and the therapeutic relationship, which has led to premature termination of therapy in some instances.

Constraints within the NHS

Despite this study's focus on practitioner psychologists in the private sector, many participants commented on their past experiences of working within the NHS in relation to CF. Participants reported experiencing pressures exerted on them as clinicians, including the rigidity of therapeutic models and interventions used, limited resources, staff shortages, and an overall reduced standard of care. The pressures in the work environment meant that some participants ended up providing emotional support to colleagues, which depleted their emotional capacity for any additional compassion towards patients. This highlights the importance of the context of the work environment in being able to provide compassionate practice. The extract below summarises the restrictions observed within the NHS.

I think previously when I worked in the NHS, the working in a team actually did – funnily enough hindered my ability to offer compassionate care to some degree because a lot of the team had their own issues that they were leaning on me for. So actually, sometimes what I was being pulled into was a lot of supporting the team staff, rather than being able to focus on patients. And also, sometimes the bureaucracy and the limits of numbers of sessions and the way we were allowed to work and so on hindered my ability to be compassionate. (P8, 42, Clinical Psychologist)

Indicators of Compassion fatigue and burnout

Some participants reflected on key signs that could lead to CF or burnout that are important to look out for. This included feelings of exhaustion, anxiety and helplessness. Participants stated that such experiences can negatively impair their well-being and functioning in their personal life, social life, and their livelihood. Specifically, stress and burnout were reported to lead to sick leave and increase the chances of making mistakes at work. Some participants have also reported not being able to meet the high demands in the healthcare system, which has increased the susceptibility of CF:

There are moments in time and circumstances where you have to give a lot more and you end up feeling you're able to give a lot less. And it gets really tricky – so we go into compassion fatigue. (P6, 53, Counselling Psychologist)

Thus, it is important to recognise the early warning signs to prevents the situation worsening. If left unaddressed, this could lead to further deterioration in the form of mental health problems such as anxiety and depression.

Part two: themes in Global Compassion fatigue

Part two of the findings focus on participants' experiences and perceptions of GCF. There were a total of three overarching themes and eight subordinate themes (see Fig. 2). These major themes included the following: 'Effects of news/social media', 'Management of news/social media' and 'Challenges faced by COVID-19'. Table 3 summarises the major themes and subthemes under GCF with associated quotes.

Effects of News/Social Media

This overarching theme explores the various experiences of participants following on from their engagement with general news and SM sources. This includes both positive and negative experiences with news sources and SM, as well as noted signs of vicarious trauma.

Negative experiences

Participants shared some of their negative emotional experiences as a result of viewing general news and SM. Some participants described news sources and SM as "poisonous" to their own mental health. The consequences of interacting with such sources led to some participants experiencing distorted perspective on things, reduced self-esteem and feelings of anxiety and helplessness. Many participants felt that SM platforms are fraught with negativity, inaccuracies, or biases in comparison to other news sources. Moreover, participants reflected that it was not always possible to objectively control what one is exposed to online. For instance, Participant 3 suggested that frequent engagement with biased, one-sided information can affect one's ability to be tolerant and open-minded:

I think there's a very big danger in life that if you have a given political persuasion and then you feed yourself information from a source that agrees with that persuasion, you are going into quite dangerous ground. You are basically forming your own echo chamber and I think that can be very

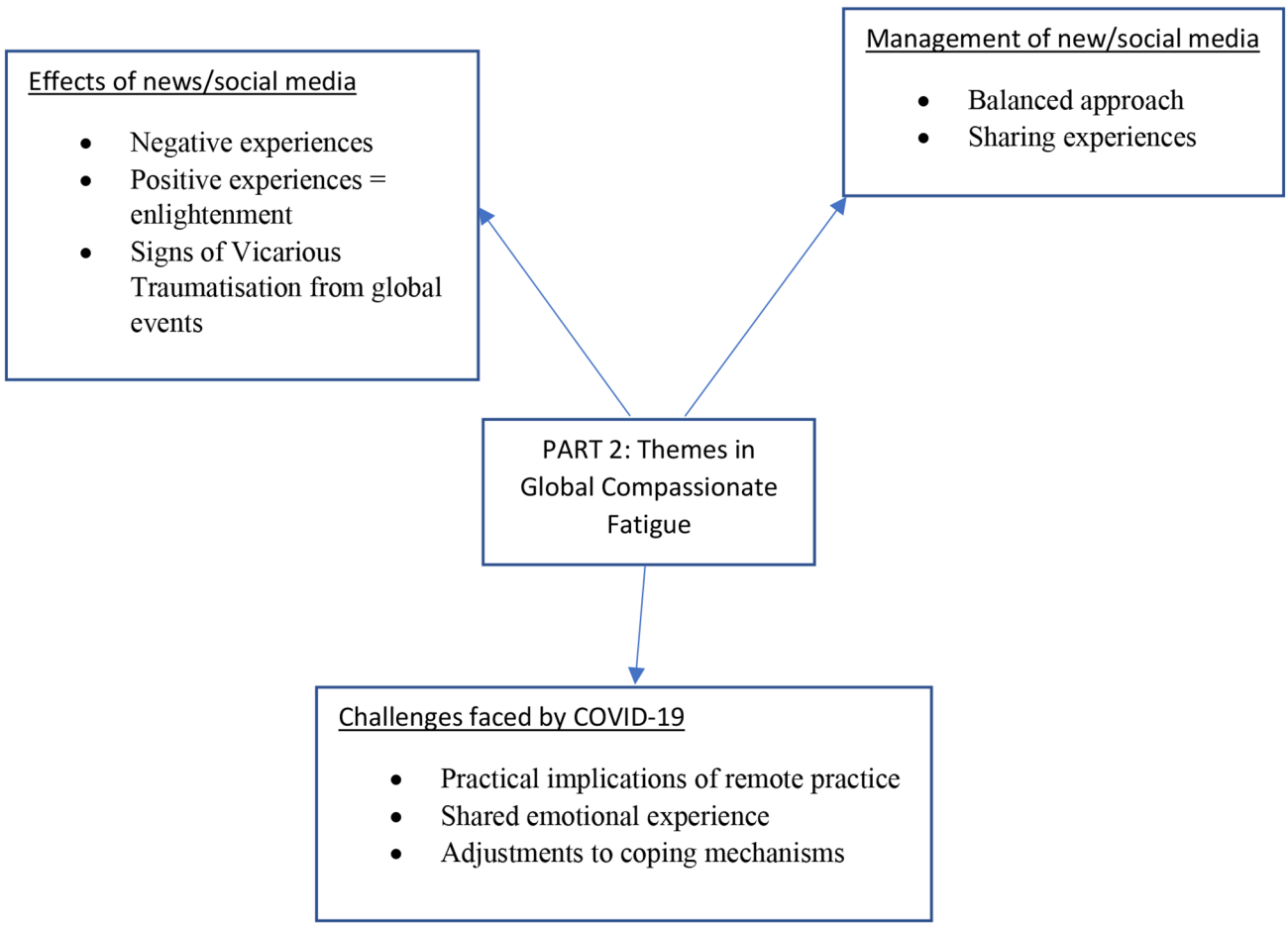

Fig. 2 Thematic map of major and subordinate themes in global compassionate fatigue

Table 3 Summary of major themes and sub-themes in global compassion fatigue

Major theme	Sub-theme	Participant quote
Effects of news/social media	Negative experiences	*'I think the thing with social media is that these things just come up whether you are in that space for them or not'. (P7)*
	Positive experiences = enlightenment	*'So I suppose social media helps keep perspective on even bigger wide world stuff, which might be helpful in my work because it is just keeping me open-minded all the time about people's experiences'. (P8)*
	Signs of Vicarious Traumatisation from global events	*COVID's a good example. I unplugged from the news, you know. I realised fairly quickly when COVID started that I was starting to get quite anxious, you know.(P3)*
Management of news/social media	Balanced approach	*'I think it's important to know what's happening in the world and what's happening around you. But I also think it's important that you are not completely dominated and obsessive with what's happening'. (P10)*
	Sharing experiences	*'I think what's really helpful and I guess it goes across all sorts of distressing things I may have been exposed to in my professional practice is seeking support. Sharing stories is basically normalising your experiences, and then sharing survival strategies is like seeing how other people are coping. What advice have they got for me? What advice have I got for them? So that can help you. I think helping other people can also make you feel more in control'. (P9)*
Challenges faced by COVID-19	Practical implications of remote practice	*I've had to adjust to working online. I've tried to think of ways to adapt my approach to this and I went on training as well so the different modalities I used could be translated online. (P6)*
	Shared emotional experience	*We're all in this so there's much more of an emotional connection with clients about this particular aspect of what's going on in all of our lives.(P7)*
	Adjustments to coping mechanisms	*I've been a bit more rigorous about self-care, so I've been a bit more on it. I've started doing—so specifics, I've started doing yoga a bit more, rather than two-three times a week. I'm doing it four-five times a week. I've started being a bit more rigorous about meditating. (P3)*

detrimental. It can affect your empathic capacity because you will begin to see the world as one thing. (P3, 41, Counselling Psychologist)

Positive experiences = Enlightenment

Despite the overwhelming majority of participants experiencing negative impacts of news and SM, some also acknowledged the potential benefits of it. Such advantages involved the opportunity to be informed and educated about different perspectives amongst the wider population. For participants, this provided a more nuanced understanding on how to potentially approach clients experiencing similar hardships. This idea is reinforced in the extract below:

I think it mostly helps me get a sense of what's going on out there. But particularly where we live through events or crises that resonate with a large number of people. I think it's really important to be able to empathise with what others might feel. And it gives me a sense of what we're all facing, and it helps me perhaps be more attentive to how it may come up in a session. (P6, 53, Counselling Psychologist)

Signs of vicarious traumatisation from global events

Participants discussed the effects of global events and how that might have led to secondary feelings of distress and the impact of this on their practice. Therefore, this subtheme highlights participants' potential experiences with VT through the media's portrayal of trauma presented on a global scale. Exposure to potentially distressing and anxiety provoking media coverage resulted in participants' responses ranging from, over-identification with the victims of a tragic event, feelings of lethargy, and demoralisation over one's limitations to change things. Some participants felt emotionally drained and distressed at the limited influence they had over global events, for example:

I think particularly things where I don't feel I have the agency to do anything about it. So crises in the Yemen, migrant crossings, starvation. Areas where I don't feel I know what to do, or that I am powerless. So that would make me feel emotionally drained, and sad, and distressed. (P9, 47, Clinical Psychologist)

Management of News/Social Media

This overarching theme explores how participants chose to manage their engagement levels with general news and SM sources. This includes setting limiting their engagement with news sources and using SM to connect with others in a beneficial way.

Balanced Approach

Many participants demonstrated a preference for having knowledge of what was happening in the world, whilst ensuring their engagement with general news or SM was not too overwhelming or anxiety-provoking. This suggests that participants had their own limits in relation to the amount of exposure to news sources and SM they can manage. This is highlighted by the following extract:

So the kind of peak of the pandemic when things felt like they were changing quite rapidly, I would just watch the ten

o'clock news every night and that is all I would do because that was kind of enough for me. And I felt I needed kind of one update a day in order to know what I needed to do and what I was meant to be doing. But I don't need to do any more than that. (P5, 54, Clinical Psychologist)

Some participants preferred to limit their engagement with any information not considered particularly useful, or potentially harmful to their well-being. Participants felt that it was important to maintain a balance between having an awareness of global events and becoming too emotionally invested with such events. For some participants, this involved viewing SM at the right quantity to avoid being too overwhelmed.

Sharing Experiences

For many participants, SM provides opportunities to connect or seek guidance from other like-minded professionals and communities. Sharing their experiences helped validate some of the challenges they face as practitioner psychologists, which was particularly helpful for some participants. Participants also stated that SM facilitates knowledge exchange of current initiatives that are accessible to clients such as, support groups or other helpful resources. It was suggested that SM does not just simply connect individuals, it can also unite individuals from an array of cultures and communities. Interestingly, participants reflected on how communities unite after adverse events (e.g., the pandemic), which motivates people to want to learn, share, and provide support. Participants felt that this builds resilience in the longer term. This is highlighted in the following extract:

That's the whole point of any adverse event whether it be to you personally, or whether it be a large or global event. That's part of resilience is to be able to kind of process, understand, acknowledge the adversity, and then also learn from it and go forward. (P10, 42, Clinical Psychologist)

Challenges faced by COVID-19

This overarching theme explores how the COVID-19 global pandemic has impacted participants' personal lives and their clinical practice.

Practical implications of remote practice

Many participants discussed the ways the COVID-19 pandemic has impacted the delivery of their sessions on a practical level, particularly the shift from face-to-face to online or telephone contact. For some, this was a very difficult shift because the requirement to adhere to COVID-19 public health rules was weighed against clients' therapeutic needs. For instance, Participant 2 felt strongly about accommodating their client's where possible: "…my instinct is if I'm following the guidelines, and if that's what the client needs, and they can't do remote, then I'm not going to say no." (P2, 58, Health Psychologist).

Despite these challenges, participants have also had to reassess the robustness of their usual treatment modality or therapeutic approaches. They reflected that online therapy can have its limitations with communication and the ability to develop a robust therapeutic relationship with clients. A major challenge comes from difficulties reading subtleties in body language in the same way as during face-to-face interactions. Some participants felt that key social ques could be easily missed during online sessions, which could have negative therapeutic implications. To compensate for this, participants reported having to work harder to build a strong therapeutic alliance remotely.

All of my practice now is online so that means there are pros and cons to that. So obviously I can do it from home, and I don't have to commute. But it also means that I think to do something online rather than in person, you have to work a bit harder for therapeutic alliance and to be able to communicate the subtleties that you're trying to.

(P10, 42, Clinical Psychologist)

Shared Emotional Experience

For some participants, the COVID-19 pandemic provided practitioners the permission to share their own emotional experiences and broke down the hierarchical divide between practitioners and their clients. This was because of the shared experience of living through the COVID-19 pandemic. Participants reported that sharing their own fears and worries about the pandemic was therapeutic to their clients as it validated and normalised their own fears.

While breaking down some of the practitioner-patient boundaries improved the therapeutic alliance in some instances, this was not experienced by all participants. For example, some participants felt that by expressing their own fears, they were moving the focus away from their clients' experiences. Using the therapeutic session to express participants' own concerns may have been reflective of their own need for emotional support through the pandemic, for example:

I was sharing that I was being affected by everything, and that I had fears and worries as well. And I suppose she felt I was less there for her as a result. So it was really nice because she brought it up and we talked about it and it was—then I realised actually, course it is something that's present. And I need to find other ways to deal with it for my own life, and it helped me change things back a little. So I suppose in a way I was probably a bit less present, a bit less

compassion, and a bit more scared and in need of help. (P6, 53, Counselling Psychologist)

Adjustments to Coping Mechanisms

This sub-theme highlights the adjustments that participants have made to their self-care routines to maintain a healthy work-life balance. The COVID-19 pandemic has amplified the pressures on individuals in navigating their personal lives, as well as the unanticipated effects on their clinical practice. Things that participants did to cope included yoga practice, going on walks, exercising using YouTube videos, and spending more time with family. These coping mechanisms enhanced their ability to maintain compassionate care as they promoted more positive physical and mental wellbeing:

I put my little psychological self-care plan in place for the lockdown, I suspect a lot of people did. I tried to make sure that I did various things like every day I did some exercise, and every day I did something social, and every day I spent some time in my garden, and every day I did some work. (P5, 54, Clinical Psychologist)

Discussion

To summarise, the aim of this study was to acquire a comprehensive understanding of private psychologists' experiences with CF and GCF on their practice. An exploration into the themes on compassionate care revealed several key findings related to factors that increase or decrease the risk of symptoms of CF among practitioners. Firstly, many participants shared what they believed to be important facets of compassionate care. This included the importance of taking a sensitive approach towards all patients throughout clinical practice. Moreover, the ability to be insightful and empathic, flexibility, patience, prioritising a strong therapeutic alliance, and avoiding any preconceived notions or biases of their patients' character. Interestingly, having an implicit motivation to help others did not emerge from the interviews. Secondly, all participants highlighted the importance of protecting one's own general well-being during their role as a practitioner psychologist. This led to discussions over prioritising supervision, self-care, rumination over personal actions and behaviours in practice, and regular training as an antecedent to caring for the welfare of others. Without adequate support or resources, a combination of factors was reported to influence the degree of compassion given to clients. Participants described how external factors such as personal circumstances and individual limitations, in conjunction with occupational factors such as pressures at work and 'challenging' patients can impede giving compassion. Organisational factors reported to have negative consequences on maintaining compassion by the psychologists included inadequate support from management, meeting high demands of their service, as well as using up the capacity to provide emotional support through supporting colleagues experiencing work-related stress. A number of participants reflected on key signs that may increase their chance of experiencing CF and burnout. This included symptoms such as anxiety and helplessness, overwhelming levels of exhaustion and a loss of empathy and motivation towards helping others. Many participants also reported on the constraints within the NHS accounting for their waning compassion in the past.

An exploration into the themes on GCF raised a number of key findings. Firstly, participants discussed positive and negative experiences of consuming information from both general news and SM sources. Positive experiences included the opportunity for self-development, professional networking, and have more exposure to the diversity of views within one's community, whilst negative experiences involved feeling demoralised over the inability to exert influence on global disasters, as well as increased exposure to potentially harmful misinformation. Participants also reflected on their indirect exposure to traumatic events which provoked VT symptoms, including emotional withdrawal, exhaustion, anger or frustration, and hopelessness. Participants reacted to these experiences by modifying their level of engagement with general news and SM in some way. Because this study took place during the height of the COVID-19 pandemic, participants' potential experiences with GCF could be explored in vivo. Overall, the pandemic created new challenges for practitioners and led to discussions about the practical, emotional, and personal implications. This included overcoming challenges with communication and interactions during online therapy sessions, adjusting therapeutic boundaries by revealing one's own vulnerabilities during therapeutic sessions, and the importance of maintaining a healthy work life balance to promote overall wellbeing.

Many of the current findings coincide with past studies that have investigated contributory and inhibitory precursors to CF (Harling et al., 2020). According to Dattilio (2015), psychologists and other mental health professionals alike have a proclivity towards overlooking the importance of their own welfare, despite working within a profession that encourages concern for the health and well-being of others. On the contrary, many participants in the current study acknowledged the fundamental need to prioritise their own personal and professional needs as a prerequisite to addressing the needs of their clients. Despite an increasing awareness of the importance of self-care, having an awareness alone is not always enough to enable practitioner

psychologists to prioritise their wellbeing (Smith & Moss, 2009). In order to sustain compassion throughout practice, participants emphasised the value of self-awareness, engagement in self-care initiatives and clinical supervision, and the implementation of a healthy work life balance to mitigate the harmful effects of CF and burnout. Harling et al. (2020) corroborated that psychologists' experiences with CF should be normalised in the hope that those suffering will be able to comfortably seek support for this, as well as remain vigilant towards its effects on them and the relationship with their self, clients, and colleagues. Furthermore, it has been suggested that clinicians should be given ample opportunity to acknowledge their experiences with CS, including the personal and mutual benefits acquired from helpful interaction with clients (Wheeler & McElvaney, 2018). According to Stamm (1995), the debilitating consequences of CF and its prevalence among HCPs could be minimised by concentrating on effective strategies to protect their well-being and functioning throughout practice.

It was unanticipated that a number of the participants would share their experiences with CF when they worked within the NHS. Raquepaw and Miller (1989) reported that private psychotherapists displayed fewer symptoms of burnout and lower job satisfaction than those within the public sector. They concluded that the source of CF or burnout development could emanate mostly from social or situational variables (Raquepaw & Miller, 1989). For instance, those in the public sector may be more likely to experience CF than those in the private sector due to increased employee meetings, additional administration processes, and the nature and complexity of the patient population. These factors coincide with the experiences shared by study participants. Further investigation of the specific distinctions between these two sectors including an exploration of the prevalence of CF and burnout is warranted. By investigating these contextual differences in further detail, we can acknowledge and understand the distinct factors that will more likely lead to CF.

The current study highlighted that some of the practitioner psychologists who were indirectly exposed to traumatic events via media outlets experienced heightened emotional duress, which may be indicative of VT. Studies have shown that perpetual exposure to negative news coverage directly diminishes one's emotional well-being (de Hoog & Verboon, 2020; Garfin et al., 2015). Nonetheless, some participants also claimed that the anxiety or psychological distress experienced from exposure to critical public events did not interfere with their clinical practice. One possible explanation for this may be that some individuals exhibited higher levels of resilience in the face of adversity, which meant they were less susceptible to the cumulative effects of VT (Holman et al., 2014). Within this context, the term 'resilience' is used to refer to one's ability to cope with and overcome the setbacks encountered from traumatic events. In response to distressing content, research has also shown that individuals feeling overwhelmed tend to limit their engagement with triggering sources to circumvent these feelings (Bright et al., 2015). A number of participants discussed the ways they set limits on their engagements with news and SM, which would have likely protected them from VT. However, setting boundaries in this way was difficult during the COVID-19 pandemic, which had significantly pervaded both the professional and personal lives of individuals (Shah et al., 2020). Consequently, the recent emergence of remote therapy to combat the spread of the virus has presented new challenges for practitioner psychologists. Many participants felt that the therapeutic relationships with their clients were threatened because of the difficulties in reading physical cues and body language during remote sessions. They therefore needed to work harder to show compassion during sessions.

The study findings have practical implications as well as implications for educators. Many participants utilised CPD and clinical supervision as opportunities to reflect on their work and explore alternative perspectives on the issues presented to them by clients. CPD events or being able to connect with other practitioners through SM was a lifeline for some private sector psychologists, who are more likely to have lone working arrangements. Based on these interviews, there is a need for more CPD events that are focused more specifically on raising awareness of CF and related concepts (e.g., GCF). Such training events could provide opportunities for attendees to reflect on their clinical practice, experiences with CF, or times they are most at risk of CF. A number of self-care strategies that mitigate the risks of CF have been discussed during the interviews and these could also be promoted more strongly during CPD events and especially target trainee psychologists. It may be that expressing feelings of CF may be a taboo in the field of psychology given that many psychologists expect themselves to sustain consistent levels of empathy over time, despite being repeatedly exposed to clients' suffering (Harling et al., 2020). To help address this, more open dialogues are needed to normalise and validate the difficulties that come with sustaining high levels of compassion in the long-term. Clinical supervision could provide the opportunity for such dialogues and clinical supervisors an avenue on which to model and reinforce reflection and self-care. These are aligned with the Fundamental values outlined in the BPS and HCPC practice guidelines, which emphasise the importance of monitoring self-care (BPS, 2017; HCPC, 2018).Given that practitioner psychologists are frontline HCPs, it is paramount that their own well-being is not neglected if they are to deliver safe and effective care to patients (Rokach & Boulazreg, 2020).

Future research should explore in greater depth the barriers practitioner psychologists face in implementing protective behaviours (e.g. self-care) to support the development of new interventions. In addition, systemic factors in healthcare settings were reported to increase the susceptibility of CF in a number of participants. Future research should investigate how these structural challenges impact CF and how they can be feasibly addressed.

The current study has its limitations. During the data collection process, some of the interviews that took place were difficult to execute as a result of technological issues such as, connection problems and delayed audio/visual feedback. Such barriers could contribute towards the disruption of an interview flow and increase the opportunity for missing data to occur (Mirick & Wladkowski, 2019). As a result of COVID-19, the process of recruiting participants became strenuous as many individuals may not have wanted to participate in a discussion regarding sensitive topics, especially if they were feeling all-consumed by the stress of current events. However, a strength of the current study is that it expands upon the limited study of CF but from the perspective of private psychologists in the UK.

To conclude, this study explored the experiences of private psychologists with CF and GCF. The findings highlighted key strategies used to mitigate the effects of CF on practice and that psychologists had good self-awareness of when their sense of compassion might be compromised. It also reiterated further insight towards GCF, with particular relevance and application to the COVID-19 pandemic.

Appendix A: Interview Guide

Compassionate Care Questions

1) Based on your professional and personal experiences, what does 'compassionate care' mean to you?*.
2) Reflecting back on your current position, can you tell me about the best example of an occasion when you provided compassionate care?*.

**Follow-up examples: How did you feel following on from this experience?*

3) Has anything facilitated or helped your own ability to provide compassionate care?*.

**Follow-up examples: Are there any other factors that you think could facilitate this for others? What advice would you give to those less experienced in the field?*

4) Has anything hindered your own ability to provide compassionate care?*.

**Follow-up examples: Are there any other factors that you think could hinder this for others? What advice would you give to those less experienced in the field?*

5) What do you think happens when compassionate care is lacking?*.

**Follow-up examples: How do you think this can impact patients, their families or other healthcare providers?*

6) Have you ever felt tired physically or emotionally after listening to patients? How do you cope with this/ How do you think you would cope if this happened?

**Follow-up examples: How often has this happened? Has this ever affected you during clinical practice? Has this ever affected you external to your workplace? Has it ever changed the way you have felt about a patient? Would you say it has affected your therapeutic relationship with any patients?*

**Most of these questions have been selected and/or adapted from a study conducted by Singh et al.* (2018).

Global Compassion Fatigue (GCF) Questions

1) What do you feel about your own news source consumption? Are there any particular avenues that you use or view more regularly than others?

**Follow-up examples: Has the way in which you consume news changed over time? If so, why?*

2) Would you consider yourself an 'active user' of social media? Which social media platforms do you use?

**Follow-up examples: How often would you say that you use these platforms? Have you ever felt that social media has affected how you would 'typically' view tragic events of human suffering? If so, how?*

3) What role, if any, do you think social media has on you as a practitioner psychologist? Has it ever had an effect on your ability to empathise when hearing about other people's tragedies?

**Follow-up examples: Have you ever felt physically or emotionally withdrawn or tired from exposure to tragic events you have witnessed through social media?*

4) From your professional and personal experiences, what advice or recommendations would you give to a colleague if they told you that they were 'overwhelmed' by their exposure to distressing news content?

**Follow-up examples: Do you think there are strategies that need to be implemented to make this easier for individuals?*

5) Throughout your years of practice, can you tell me about a specific global or national past or current event where you have experienced and responded with intense emotions, thoughts or feelings?

**Follow-up examples: How did you feel? Would you say that you were feeling physically or emotionally withdrawn? How did you overcome this barrier?*

6) In light of the COVID-19 pandemic, how has this impacted your own clinical practice and self-care? Has the news and social media coverage of this virus, in terms of individuals and families who have experienced the virus itself and its repercussions affected your self-care or practice in any way?

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Statements and Declarations

Conflict of interest The authors have no competing interests to declare that are relevant to the content of this article.

Ethics approval and consent to participate The study was approved by the [UNIVERSITY NAME – anonymised for peer review] Psychology Department's ethics committee. The authors have no competing interests to declare that are relevant to the content of this article. All participants provided written and verbal informed consent prior to taking part in the study.

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