The Experience of Burnout among Psychologists in South Africa

by

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ABSTRACT

Psychologists are at risk for burnout due to the emotional challenges and structural difficulties encountered in their daily work. Given the high prevalence of burnout amongst psychologists, a considerable amount of research has been conducted on the effects, risks and management of burnout. However, despite the proliferation of burnout literature, the majority of research has been restricted to quantitative analysis, with a paucity of studies exploring the phenomenon from a qualitative standpoint. More so, even fewer studies have explored the lived experience of burnout amongst psychologists. Thus, this study explored the experience of burnout among psychologists using interpretative phenomenological analysis. Six psychologists working in South Africa were purposively sampled and interviewed in order to collect rich, detailed accounts of their experience and perceptions of burnout. Five super-ordinate themes emerged from the data: (1) description of burnout reflects inner experience; (2) idealised expectations of self; (3) effects are multi-faceted; (4) risky business (5) the self-protection: a lofty goal. Findings from the study highlighted the uniqueness of individual experience even within commonalities. Findings demonstrated that the impact of burnout is far reaching and affects the psychologist in multiple areas of functioning. Findings also suggested that burnout can be self-sustaining and various processes such as self-stigma and stigma from colleagues intersect to create barriers to protection and effective resolution of burnout. Most notably, research findings suggested that psychologists' self-concept may be impacted negatively by burnout which, in turn, may cause psychologists to work harder and invest more emotionally, possibly giving rise to a self-perpetuating cycle of burnout. These findings have implications for the training, supervision and support of psychologists in practice in addition to the prevention and management of burnout.

Keywords: burnout; compassion fatigue; emotional exhaustion; vicarious trauma; secondary traumatic stress; stigma

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1 INTRODUCTION

1.1 Introduction

Psychoanalyst Herbert Freudenberger first introduced the concept of burnout nearly five decades ago. He defined it as “to fail, wear out, or become exhausted by making excessive demands on energy, strength and resources” (Freudenberger, 1974, p. 159). The concept of burnout has received increasing attention in research in the past few decades (Maslach & Leiter, 2016). Early research on burnout focused on the helping professions due to the interpersonal and emotional stress experienced in the profession (Bakker, Demerouti & Sanz-Vergel, 2014).

Psychologists, in particular, undergo extensive interpersonal and emotional stress in their professions. Research demonstrates that burnout and its related problems are commonly experienced by psychologists (Du Plessis et al., 2014; Jordaan et al., 2007a; McCormack, MacIntyre et al., 2018; Phillip, 2004; Radeke & Mahoney, 2000; Simionato & Simpson, 2018). Moreover, Simionato and Simpson’s (2018) review of the literature indicated that more than half of the psychologists within the sample experienced burnout at moderate to high levels.

The role of psychologists is to engage with the subjective experiences of their clients through a non-hierarchal client-therapist relationship (Cooper, 2009). Helping professionals, such as psychologists, are vulnerable to stress and burnout (Paton & Goddard, 2003) due to their jobs requiring face-to-face, emotionally taxing engagement with distressed individuals for an extended period of time (Cordes & Doherty, 1993). Psychologists are required to be reflexive in therapy and thereby need to engage in self-development to obtain an increased sense of self-awareness (Lane & Corrie, 2006). Although personal development can bring about necessary and positive changes in the psychologist, it can also cause distress in the individual as new or difficult information is processed. Helping professionals are often naturally empathetic and altruistic and are trained to be sensitive to the needs and emotions of others (Skovholt, 2012). They often have a strong moral obligation to their clients, and this too influences their vulnerability (Skovholt, 2012). In addition to sensitivity towards their clients in session, psychologists are encouraged to be sensitive to broader social justice issues such as discrimination and unequal treatment of individuals (Cutts, 2013). This combination of sensitive, compassionate individuals working with distressed individuals in distressing situations makes for a unique experience of burnout that isn’t captured by traditional burnout models.

Freudenberger's initial conceptualisation of burnout has since been expanded in research and continues to be the subject of conceptual dissection and study. Despite this, literature still relies on the three-dimensional model of burnout proposed by Maslach et al. (2009) and largely fails to capture the essence of the burnout experience in helping professions. As with their clients, psychologists are beings embedded within their own social, relational and cultural context (Cooper, 2009). The experience of burnout and perception of such is subjective and embedded within context. Although research has demonstrated that there are commonalities in burnout such as risk factors and symptoms, each experience is likely to be unique in certain ways (Smith et al., 2009). No single experience can be used to describe all others. This is particularly relevant within the South African context whereby contextual factors such as history, race, socioeconomic status and culture are so diverse. Thus, the present study seeks to deepen understandings of South African psychologists' lived experiences of burnout through the application of an Interpretative Phenomenological Analysis framework.

Findings from the present study could contribute to existing burnout models that fail to fully capture the burnout experience in psychologists. In addition, findings could augment burnout literature in South Africa by exploring the context-specific experience of burnout.

1.2 Overview of chapters

In the introductory chapter, a brief overview of the study is given for further elaboration in subsequent chapters. Chapter 2 reviews the extant literature on burnout with a focus on burnout in psychologists. The literature was reviewed thoroughly in order to provide a basis for the study rationale and aims. The chapter begins by defining burnout and goes on to review the research on prevalence risk factors, the process of burnout, the impact on various areas of functioning, coping strategies employed by psychologists and barriers to help-seeking, how burnout has been researched in the past and a review of the interpretative phenomenological analysis framework. Chapter 3 provides the study rationale and research questions that the study engages with are stated. Chapter 4 explores the theoretical framework of Phenomenology and its value in the study. Chapter 5 presents the research design and methodology that was used to answer the research questions stated in Chapter 2. The methodological framework, sample, methods of data collection and analysis of the data are described in detail to allow for replication of the study by other researchers. The chapter concludes with the consideration of ethics employed during the study. Chapter 6 presents the research findings. In accordance with the interpretative phenomenological analysis (IPA) methodology, the emergent and sub-

ordinate themes obtained from the data are reported and tabulated in this Chapter. Examples from the transcripts are included to illustrate each theme. A summary of each participant's experience is given before presenting the data from each theme. Chapter 7 presents the discussion and integration of the super-ordinate themes in relation to the extant literature on burnout. In Chapter 8 the study is concluded. The importance and implications of findings are discussed as well as the limitations of the study and recommendations for future research.

2 LITERATURE REVIEW

2.1 Defining burnout

Burnout, as a construct, can be understood as a multidimensional model of stress which depicts the individual's experience of stress as embedded within a particular context. Maslach's definition of burnout and the accompanying burnout measure, the Maslach Burnout Inventory (MBI) are the most widely used constructs in burnout literature (Schaufeli, Leiter & Maslach, 2009). According to Maslach et al. (2009), burnout comprises three components: emotional exhaustion, depersonalisation and lack of a sense of personal accomplishment. Emotional exhaustion is the feeling of being emotionally depleted – in simple terms, having no emotional energy or resources left to give. Depersonalisation is exhibited by feelings of disconnection from oneself and one's clients. Lack of personal accomplishment describes the feeling of being unhappy and dissatisfied with one's work performance. Schaufeli and Taris (2005) argue that in addition to exhaustion, depersonalisation and cynicism, burnout should include concepts of helplessness, tedium, inner void and work-related fatigue. In recent years, some researchers and clinicians have proposed that concepts such as 'moral injury' be included in the conceptualisation of burnout in healthcare workers (Ford, 2019, p. 125). Moral injury is defined as "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009, p. 700). However, formal research has yet to be carried out in this area. This term could add an interesting element to existing burnout research going forward and may help to address the shortcomings of existing models of burnout in aptly describing burnout in healthcare professionals.

2.2 Prevalence of burnout

Burnout has risen considerably in recent years amidst increasing demands placed on the working population (Glint, 2020). A systematic review of the literature revealed that burnout was extremely prevalent (McCormack et al., 2018) in psychologists and allied mental health professionals. Moreover, psychologists experienced emotional exhaustion more frequently than other dimensions of burnout (McCormack et al., 2018) and reported higher levels of emotional exhaustion than other mental health professionals (Dreison et al., 2016). Due to the emotionally demanding and interpersonally involved nature of a psychologist's work, it is unsurprising that emotional exhaustion is so prevalent (Maslach et al., 2001).

Du Plessis et al. (2014) determined the prevalence of burnout among allied healthcare workers working in the physical rehabilitation sector in South Africa. Their results showed that burnout was high amongst their sample; 57.14% suffered from emotional exhaustion, 38.77% from decreased personal accomplishment and 20.4% from depersonalisation. Jordaan et al. (2007a) investigated burnout among South African clinical and counselling psychologists. Approximately half of the participants showed moderate to high levels of burnout. The researchers noted that this is higher than in previous studies (Metz, 1987; Smith, 1998), suggesting that there may be an increase in the incidence of burnout over time.

The prevalence of burnout among psychologists confirms that they are particularly vulnerable for burnout. The specific factors that put psychologists and other mental health professional at risk will be discussed below.

2.3 Risk factors for burnout

Burnout is depicted to result from chronic stress and frustrations that exceed one's personal tolerance and render one's coping mechanisms ineffective (Rogers & Dodson, 1988 cited in Mandy, Sacter & Lucas, 2004). Various factors have been found to place mental healthcare practitioners at risk for burnout. Although these factors may not have a direct causal relationship with burnout, these factors are more likely to impair one's coping mechanisms and thus predispose one to burnout.

2.3.1 Personal risk factors

Research has demonstrated that some psychologists are more at risk for burnout than others due to certain personality traits (McCormack et al., 2018). Personality factors such as neuroticism, perfectionism, excessive conscientiousness, rigid thinking style, introversion, egocentrism and competitiveness are associated with higher rates of burnout (Simionato & Simpson, 2018). As such, a well-integrated personality could be a protective factor for burnout (Sandoval, 1993).

In addition to personality, the level of experience of a psychologist has been found to influence the risk for burnout. Research by Jordaan et al. (2007a) found that psychologists who had been practising for longer were less likely to show signs of burnout compared to their less experienced colleagues. In a review of the literature, Simionato and Simpson (2018) also found that age was frequently inversely associated with burnout. Their review also demonstrated that

psychologists who had less experience and had a tendency to become over-involved in clients' problems were at higher risk of experiencing burnout.

2.3.2 Demands of therapeutic work

The act of psychotherapy in itself has inherent risks (McCormack et al., 2018). Major sources of stress for psychologists appear to be embedded within difficulties associated with the therapeutic process such as client suicide attempts, resistance and anger from the client (Radeke & Mahoney, 2000). Managing negative transference of clients with negative dispositions can also put therapists at risk for burnout (Hammond, Crowther, & Drummond, 2018). Secondary traumatic stress, the emotional demands of counselling, a lack of personal resources and social support have also been found to play a role in burnout (Fourie, 2004). The stress of helping distressed individuals is exacerbated by the confidential and isolated nature of the profession (Hammond, Crowther, & Drummond, 2018; Norcross & Brown, 2000; Skovholt, 2012).

Clients are typically in a state of severe distress when they present to therapy, particularly in South Africa, where violence, unemployment, historical discrimination and socio-economic disparity are rife (Jackson et al., 2010). Research by Jordaan et al. (2007a) found that in South Africa, the socio-economic status of the client was one of the most significant predictors of stress in psychologists in South Africa. Jordaan et al. (2007a) also found that the severity of mental illness was a significant predictor of stress in South African psychologists. Due to the stigma surrounding mental illness and limited access to mental healthcare in primary healthcare settings (Peterson, 2000), people may ignore their mental health problems until they become unbearable. This results in South African psychologists seeing large quantities of people in extreme distress. In addition to this, high rates of violent crimes in the country lead psychologists to frequently being exposed to trauma vicariously, leaving them vulnerable to vicarious traumatisation (Sui & Padmanabhanunni, 2016).

2.3.3 Organisational factors

Research has identified a number of organisational risk factors (Maslach et al., 2001; Schaufeli & Enzmann, 1998), however, few of them relate directly to psychologists. Endriulaitienė et al., (2019) acknowledge the need for more research on the organisational factors impacting burnout in psychologists. One of the primary risk factors that has been identified is a high workload (McCormack et al., 2018). Much like other professions, excessive workload and mismanaged workload has been found to increase risk for burnout in psychologists (Hammond, Crowther,

& Drummond, 2018; McCormack et al., 2018). The total hours of work per week spent on professional activities was found to be a reliable predictor of emotional exhaustion (Kaden, 1999) which is regarded as a significant element of burnout. In addition to workload, work setting appears to influence burnout rates with clinicians working in hospital settings reporting higher rates of burnout than those working in private practice (Rosenberg & Pace, 2006; Vredenburgh et al., 1999).

In South Africa, there are insufficient psychologists to meet the demand of the population (HPCSA, 2018), leading to a heavy case load, particularly for those working in clinical and public health settings (Vredenburgh et al., 1999). Jordaan et al. (2007a) found that client load was one of the most significant predictors of stress in psychologists in South Africa. There are less than 9 000 registered psychologists to service a nation of more than 57 million people in South Africa (HPCSA, 2018; World Population Review, 2017); that equates to 6 333 persons per one psychologist – an impossible load.

Workplace autonomy and having a sense of control over one's work and resources have also been found to reduce risk of burnout (McCormack et al., 2018). Mental health professionals working in large public hospitals are likely to have little control over their work, particularly in the overburdened South African health system. As such, psychologists are vulnerable to experiencing burnout due to a plethora of factors operating within both personal and organisational arenas. In addition to literature on risk factors, literature has explored the process of burnout which is connected to several of the predisposing factors mentioned above.

2.4 The process of burnout

Unlike acute stress, burnout develops gradually in reaction to ongoing occupational stress (Maslach & Leiter, 2007). Chronic exposure erodes at the individual's psychological, social and physical well-being. Because the onset of burnout is prolonged, the duration tends to be chronic (Maslach & Leiter, 2007). Herbert Freudenberger (1982) developed a 12-stage model of burnout in order to explain how burnout progresses. The stages are as follows: (1) the compulsion to prove oneself – ambition and a desire to prove oneself can turn into unhealthy determination and compulsion; (2) working harder – excessively high personal expectations can lead to persons taking on more work than they can cope with; (3) neglecting needs – not leaving sufficient time for eating, sleeping and socialising; and (4) displacement of conflicts – the person may start to feel distressed but cannot recognise the source of the distress. Physical

symptoms may emerge at this point and include: (5) revision of values – one may become isolated, dismiss things that were previously important to them such as friend or hobbies, and emotional blunting may occur at this stage; (6) denial of emerging problems – the person may become intolerant of colleagues and other people at this stage and become generally cynical; (7) social withdrawal and possible feelings of hopelessness and lack a sense of direction at this stage, or substance use in order to cope; (8) obvious behavioural changes – persons experiencing this stage become shy, apathetic, no longer engage with others or in activities and experience increased feeling of worthlessness; (9) depersonalisation – a person in this stage feels disconnected from oneself and may no longer sees oneself or others as valuable, and life feels mechanical; (10) inner emptiness – the person feels empty inside, and leisure time is no longer enjoyed; (11) depression – this stage and burnout syndrome often occur together, and the person becomes indifferent to life and those around him/her, feels hopeless and exhausted, and life and the future are meaningless to him/her; and (12) burnout syndrome – persons experiencing burnout syndrome may experience suicidal thoughts and feel desperate to escape their situation, and they experience a break-down of mental and physical capabilities and may require formal healthcare intervention at this stage. These stages do not necessarily follow each other consecutively – some stages may be skipped, and some can be experienced simultaneously (Freudenberger, 1982).

The process described above gives some insight into the potential impact of burnout on a clinician's personal and work life. Other process models exist (Demerouti et al., 2001), however, the model described encompasses the experience most holistically. Research demonstrates that the impact is systemic and influences multiple areas of a psychologist's functioning (McCormack et al., 2018).

2.5 The impact of burnout

2.5.1 Occupational impact

People who work in professions that involve spending extensive time with clients who were in a state of chronic stress and tension are particularly vulnerable to experiencing emotional, physical and occupational exhaustion (Maslach & Jackson, 1979). According to Skovholt (2012), the difficulty in therapeutic work is that the therapist is required to be empathetic when hearing about the terrible and tragic events in clients' lives. This process demands a vast amount of emotional energy and continual output, and, without significant replenishment, it

can take its toll on the therapist's own mental health and job satisfaction. Not only is a psychologist required to be interested, engaged and energetic when working with distressed individuals, they are expected to do so repeatedly over prolonged periods (Skovholt et al., 2004).

Because burnout can impair one's ability to do one's job, it can also negatively influence the quality of patient care (McCormack et al., 2018; Rupert, Miller & Dorociak, 2015). Dimensions of burnout such as depersonalisation are of particular concern as it can cause the psychologist to emotionally disengage from their clients (Maslach & Jackson, 1981; Sui & Padmanabhanunni, 2016). Skovholt (2012) describes two kinds of burnout occurring in therapists: meaning burnout and caring burnout. Meaning burnout can result in the lack of enjoyment and interest in the work, client progress stagnates and motivation for the work wanes. Caring burnout results in a diminished capacity to connect and attach to the client, with the psychologist losing her/his ability to care and empathise.

In mental health professions, the therapist is the central professional instrument for client recovery, development, mental health and transformation (Skovholt, 2012). Any form of burnout is likely to reduce the therapist's capacity to do their work (McCoy Lynch, 2012). It is, therefore, paramount that the ability of the therapist to foster this relationship is maintained. Figley (2002) emphasised the cost of caring for distressed individuals and highlighted the need for psychologists to deal with their own stress in order to be empathetic and emotionally invested.

2.5.2 Mental health

Compassion fatigue, resulting in a negative attitude towards one's job and a loss of concern for one's clients, can develop into a negative self-concept (Mandy, Sacter & Lucas, 2004). Mandy et al. (2004) state that difficult clients can threaten self-efficacy, causing feelings of self-doubt.

In addition to the impact on one's self-esteem, burnout has also been closely linked to post traumatic stress disorder (PTSD), depression and anxiety (Brady, Healy, Norcross & Guy, 1995; Figley, 2002; Pearlman & Saakvitne, 1995; Stamm, 2010). Sui and Padmanabhanunni (2016) explored the experiences of psychologists working with traumatised individuals in South Africa. Participants experienced negative changes in their worldview, characterised by cynical views of the world and others. Participants also experienced symptoms of PTSD such as intrusive memories, persistent negative emotional states and increased arousal and

reactivity. Symptoms of depression that may be experienced as a result of burnout include mental stress, fatigue, a decreased sense of personal accomplishment, negative affect, depersonalisation, reduced motivation and insomnia (Hammond et al., 2018). Jordaan et al. (2007b) explored the level of emotional stress experienced by South African psychologists, finding that more than half of the participants had above average anxiety levels and more than half were mildly depressed. The researchers found that negative coping strategies, including self-blame, self-distraction, denial, and substance use, significantly predicted anxiety and depression. Their results indicate that psychologists are not effectively managing their emotional health, resulting in anxiety and depressive symptoms.

Research has shown that that in addition to the above mental health concerns, burnout can lead to disruption in personal relationships (Brady et al., 1995).

2.5.3 Relationships

Relationships have always been at the centre of descriptions of burnout in psychologists. The relationships with clients, colleagues and supervisors can either be sources of emotional strain and stress or a resource for coping (Maslach & Leiter, 2007). If these relationships are characterised by a lack of support and conflict, they put a person at greater risk for burnout (Maslach & Leiter, 2007), and may cause a breakdown in relationships at work. There is also evidence to suggest that burnout has negative effects on an individual's home life (Maslach & Leiter, 2007) and personal relationships (Kotler, 1993; Maslach & Leiter, 2016; Papadomarkaki & Lewis, 2008). Catanese (2010) found that therapists struggled to regulate their emotions when burnt-out and as a result, they experienced a deterioration in emotional connections with others. While this is pertinent to the client-therapist relationship, the impact on personal relationships should not be neglected. Archer (2020) found that trainee psychologists who had an excessive workload sacrificed their personal relationships in order to keep up with the demands of training. It is possible that psychologists dealing with heavy workloads would do the same. In addition to personal relationships being affected, burnout can impact one's health.

2.5.4 Physiological impact

Melamed, et al. (2006) reviewed the literature on the health implications of burnout and concluded that there is sufficient evidence to linking burnout with "ill health, including the metabolic syndrome, dysregulation of the hypothalamic–pituitary–adrenal axis along with

sympathetic nervous system activation, sleep disturbances, systemic inflammation, impaired immunity functions, blood coagulation and fibrinolysis, and poor health behaviours" (p. 327). Chronic stress and burnout are associated with increased allostatic load (an indicator of biological strain or 'wear and tear' on the body) (Juster et al., 2011). In addition, many individuals experiencing burnout report somatic symptoms such as physical exhaustion, headaches and muscle tension (Sui & Padmanabhanunni, 2016). In addition to this, participants reported somatic symptoms such as physical exhaustion, headaches and muscle tension.

It is clear that burnout affects multiple areas of a psychologist's functioning and decreases their overall well-being. Practitioner well-being is associated with increased practitioner empathy (Shanafelt et al., 2005), thus, it is a tenable assumption that the better therapists care for themselves, the more effectively they can help people and the more competent they will be as helping professionals.

2.6 Coping strategies and help-seeking behaviours

Jordaan et al. (2007) state that there is a paucity of literature on coping strategies used by psychologists to mitigate burnout. The majority of extant research is made up of mixed mental health professionals, making conclusions specific to psychologists unfeasible. The researcher of the present study identified a few strategies in the literature, however the majority of these strategies' effectiveness have not been thoroughly tested empirically, indicating a need for further research in this regard.

2.6.1 Self-monitoring

Schwebel and Coster (1998) found that self-awareness and self-monitoring is the most significant factor in optimal functioning. Moreover, self-monitoring one's distress levels is important in preventing burnout (Norcross & Brown, 2000). When a person experiences a distressing physical, emotional or interpersonal state, and they perceive it as problematic enough to need care, they will begin to seek help (Corigan et al., 2005). Practitioners can prevent or mitigate their experience of burnout by fostering resilience and employing effective self-care (Skovholt, 2012).

2.6.2 Drawing on social support

Taking responsibility for replenishing oneself personally and professionally is an important process (Norcross & Brown, 2000). The use of helping relationships and social support such as peer groups, loving relationships, close friendships and clinical supervision have been found to be an effective form of self-care. Support groups in which psychologists can discuss common difficulties and express emotions in a healthy way can be a valuable therapeutic experience. Researchers also suggest less experienced psychologists consult regularly with experienced colleagues to reduce feelings of incompetence (Jordaan et al., 2007a; Norcross & Brown, 2000; Radeke & Mahoney, 2000). Personal therapy can be a constructive method of self-care (Norcross & Brown, 2000). Research shows that balancing professional and personal life and engaging in new and different work situations, such as different forms of therapy and/or different types of clients, is a useful way to renew and refresh the therapist (Norcross & Brown, 2000; Rupert, 2015).

2.6.3 Maintaining realistic expectations

Many psychologists become disillusioned with their work when therapeutic outcomes do not meet their expectations (Skovholt, 2012). Tendency to self-blame can disable a therapist's adaptive resources (Norcross & Brown, 2000). It is thus important to avoid idealist goals and self-blame. Moreover, research shows that acknowledging the rewards of psychological work is equally as important as acknowledging the hazards (Norcross & Brown, 2000). Radeke and Mahoney (2000) found that some psychotherapists felt that despite their work being emotionally taxing, it made them wiser, more aware and accelerated their own psychological development thereby increasing their ability to enjoy life.

2.6.4 Maintaining boundaries

In order to deliver competent services, therapists need to learn to manage their burnout effectively. One way of doing so is to practice 'boundaried generosity' (Skovholt, 2012). Skovholt (2012) describes boundaried generosity as a paradoxical concept of giving of oneself and protecting oneself at the same time. Too much empathy can lead to a therapist losing themselves in the client's world, reducing both personal and professional effectiveness; too little empathy, on the other hand, removes the human caring that is central to the profession (Skovholt, 2012).

2.6.5 Mindfulness

Finally, research has shown that continuous educational programmes on mindfulness-based stress reduction techniques have a significant association with decreased burnout symptoms and enhanced mental well-being for a range of healthcare providers (Goodman & Schorling, 2012). Silver et al. (2017) examined genetic counsellors who experienced a high rate of burnout and compassion fatigue. The researchers found that mindfulness was positively correlated with work engagement and empathy. Mindfulness was negatively correlated with compassion fatigue and burnout.

Jordaan et al. (2007) noted that in addition to a lack of research on effective coping mechanisms, no research on stress and coping has been conducted on psychologists in South Africa. Accordingly, qualitative research that engages with psychotherapists' subjective experiences of burnout is suggested in order to identify potential coping strategies and potential barriers. This will allow statistical, empirical research to follow to identify the effectiveness of suggested strategies.

2.7 Barriers to help-seeking

Despite the plethora of literature on burnout, many psychologists do not receive the help they need due to various barriers. On review of the literature, the primary barriers to help-seeking behaviour asserted in studies are: stigma, cultural barriers (Corrigan et al., 2015) and ethical conflicts (Simionato et al., 2019)

2.7.1 Cultural barriers

Research on how culture impacts help-seeking has been flawed, as researchers have grouped cultures broadly by continent, i.e., 'African' or 'Asian' (Corrigan et al., 2015) when in reality there are multiple diverse cultures and races within each continent. Research has explored beliefs about mental illness as a possible barrier to help-seeking, however, assuming that one belief is held by an entire culture is akin to stereotyping. Literature shows there is heterogeneity within every culture (Corrigan et al., 2015). Moreover, it is unclear whether help-seeking strategies proposed by literature are culturally relevant in a South African society.

2.7.2 Stigma

A review of the literature shows that many mental health professionals endorse negative stereotypes and stigmatise mental illness (Schulze, 2007). Stigma surrounding mental illness and other mental difficulties impacts on a person's willingness and ability to seek help (Corrigan et al., 2015). Psychologists who have mental illness are often questioned as to their ability to see patients, even if their illness is under control, and feel judged by their colleagues (Gilroy et al., 2001; Jamison, 1998). If psychologists hold negative stigma towards others with mentally illness, it is likely that they will hold these same negative views towards themselves if they become burnt out or mentally ill. Research shows that many mental health professionals experience self-stigma (Endriulaitienė et al., 2019). Self-stigma is the negative attitude towards mental illness and the negative attitude towards the self as a result of having a mental illness. Not only does self-stigma impair help-seeking, it can also negatively impact a person's self-esteem and quality of life (Rüsch et al., 2010).

Despite the proliferation of research on stigma as a barrier to help-seeking behaviours, the literature on self-stigma in psychologists with burnout is scant (Endriulaitienė et al., 2019). Research has vastly neglected the lived experience of this phenomenon, with the majority research being confined to quantitative analysis. Having an in-depth rich understanding of the barriers to help-seeking is essential within the mental health field.

2.7.3 Ethical dilemmas

Psychologists may hesitate to seek help for, or disclose, their burnout due to fear of ethical implications. According to Allen (2008), therapists often overlook their ethical responsibility of ensuring they are fit to practice. According to the Health Professions Act (Act No. 56 of 1974), should a psychologist find him/herself impaired he/she should take adequate measures to address this or limit, suspend or terminate professional duties. Providing competent service delivery includes being emotionally unimpaired. Severe burnout can impair a therapist's ability to practice, therefore, it is paramount that therapists recognise and manage burnout appropriately. Failure to do so can be regarded as a violation of beneficence as it is the therapist's responsibility to ensure therapy benefits the client and is in the client's best interest. Psychologists also have a duty to conform to professional codes such as competence (Allen, 2008). It can be argued that a therapist practicing with severe burnout, particularly those experiencing compassion fatigue, is in violation of this code as they may no longer be

competent. Regarding professional competence, the Health Professions Act (1974) states that a psychologist must refrain from professional activities should they be unable to perform in a competent manner due to mental or emotional impairments.

Despite a wealth of information on burnout prevention, management and barriers to help-seeking, mental health professionals continue to experience burnout at high rates. This suggests a possible disconnect between research and reality, and indicates a need for further research in this regard. In addition, research has primarily focused on barriers to help-seeking for mental illness (Corrigan et al., 2015) thus it is unclear whether these barriers are relevant in cases of burnout.

2.8 Research on burnout

Although various studies have examined burnout in healthcare professionals, research has been predominantly quantitative (Ackerley et al., 1988; Huberty & Huebner, 1988; Lee, Lim, Yang & Lee, 2011; Huebner, 1992; Huebner 1993; Huebner 1994; Raquepaw & Miller, 1989; Rupert & Morgan, 2005; Sandoval, 1993; Simionato & Simpson, 2018). A review of the literature reveals that the most common quantitative method of study used to examine burnout among psychologists is a cross-sectional study using self-report surveys. This method of study was used in 36.9% of cases. Far less common, used in only 2.5% of the studies, were qualitative interview measures (Simionato & Simpson, 2018). Burnout was explored within an IPA framework in several studies (Archer, 2020; Crim, 2013; Moodley, 2009; Petker, 2016; Razo, 2018; Volpato et al., 2018), however, no study focuses on the experience among registered psychologists from a South African perspective, using IPA. As a country with great diversity, a study of this nature would likely elicit valuable findings.

2.9 Interpretative phenomenological analysis

2.9.1 <u>Theoretical foundations of IPA</u>

IPA draws on the theoretical concepts of three main approaches: phenomenology, hermeneutics and idiography. Phenomenology is primarily a philosophical approach and is concerned with the human experience (Smith et al., 2009). Phenomenology is described in greater detail in the following chapter, Theoretical framework.

The second major influence of IPA is hermeneutics. Hermeneutics is described as the theory of interpretation. Three important theorists who have contributed to the field of hermeneutics are Schleiermacher, Heidegger (covered under phenomenology) and Gadamer. Schleiermacher viewed interpretation as an intuitive process that, if engaged in correctly, could produce an understanding even greater than the person who has experienced it. IPA does not view the interpreter as knowing more than the participant, however it does acknowledge that interpretation by the researcher can offer meaningful insight that was not previously considered by the research participant (Smith et al., 2009). Schleiermacher believes that the process of interpretation makes the unconscious conscious; in this way, the researcher can have a meaningful contribution to wholly understanding the experience (Smith et al., 2009). Gadamer's beliefs were connected with Heidegger's hermeneutic beliefs. He emphasised the importance of uncovering one's preconceptions and understanding them, rather than putting them to one side entirely. He also believed that a researcher may only notice their preconceptions by engaging with the research process. IPA is underpinned by hermeneutics in that the researcher is responsible for unpacking and making sense of a phenomenon, beyond how it initially appears (Smith et al., 2009).

The third key theoretical underpinning of IPA is idiography. Idiography concerns itself with the particular as opposed to nomothetic explanations that focus on universal or population level claims (Smith et al., 2009). Like idiography, IPA is interested in particular experiential phenomena from the perspective of particular people in a particular context. Idiography does not reject generalisations outright but rather develops them cautiously, from the particular. Nomothetic conclusions are unable to provide explanations for individual psychological functioning, thus idiography prefers to focus on the individual when it concerns experience. Instead, idiography analyses single cases before making more general statements from them. IPA has adopted this procedure it its data analysis (Smith et al., 2009).

2.9.2 Assumptions and focus of IPA research

IPA is interested in detailed examination of the lived, personal, human experience. IPA aims "to explore in detail how participants are making sense of their personal and social world, and the main currency for an IPA study is the meanings particular experiences, events, and states hold for participants" (Smith & Osborn, 2003, p. 53). Thus, this approach focuses on participants' experiences, understandings, perceptions or views on particular phenomena. These phenomena are usually experienced subjectively and are of particular significance to the

participant (Smith et al., 2009). IPA attempts to capture particular experiences of particular people and what the experience means to them (Pietkiewicz & Smith, 2012). In psychology, meaning-making is the process of how people perceive, understand or make sense of life events, relationships, and the self (Ignelzi, 2000).

The participants' experience is made sense of through the researcher's own interpretation. The researcher attempts to explore their experience without preconceived ideas, expectations and without heavy reliance on theory. For this reason, research questions centre around understanding of their experience, how they make sense of their experience, and, on a larger scale, the world (Pietkiewicz & Smith, 2012). "In choosing IPA for a research project, we commit ourselves to exploring, describing, interpreting and situating the means by which our participants make sense of their experiences" (Smith et al., 2009, p. 43).

IPA requires 'rich' data, however, this is a subjective term. In terms of IPA, rich data means that participants should have been granted an opportunity to tell their stories, to speak freely and reflectively, and to develop their ideas and express their concerns at length (Smith et al., 2009, p. 58). Because IPA is strongly rooted in the hermeneutic form of phenomenology, IPA analysis involves interpretation (Smith et al., 2009). IPA involves double hermeneutics in that the researcher is interpreting the interpretation of the participant (Smith et al., 2009; Smith & Osborn, 2003) – the researcher is required to make sense of how participants interpret their experience. As mentioned above, the purpose of the researcher is not to 'bracket' their preconceptions but to rather be aware of them and practice reflexivity throughout the process. The researcher might not be aware of their own preconceptions prior to the study, therefore reflection and working in a cyclical manner is required (Pietkiewicz & Smith, 2012). Due to the influence of idiography, IPA is interested in detailed and deep analysis of the particular. However, while analysing the data, attention must be shown to not only the individual experience, but similarities in their patterns of meanings and distinct variations in the patterns. Thus, IPA analysis is not only interested in the unique but in divergence and shared patterns of meaning (Smith et al., 2009)

An important rationale for IPA is that it can be regarded as 'applied psychology' or 'psychology in the real world' (Smith et al., 2009, p. 10). IPA researchers are interested in the human predicament and how people engage with the world (Smith et al., 2009). Interpretative phenomenology adds another interesting lens in that it requires a psychologist to interpret other

psychologists' interpretations of the burnout experience (Pietkiewicz & Smith, 2014; Smith & Osborn, 2003).

2.9.3 Extant IPA Research on Burnout in Mental Healthcare Professionals

Within the body of qualitative research, some were conducted using IPA, which aims to explore the subjective, lived experience of participants (Smith et al., 2009). The following studies serve to expand the understanding of the experience of burnout amongst mental healthcare professionals and provide a richer view of burnout through their qualitative design.

Archer (2020) explored the experience of burnout in counselling psychology trainees using IPA. Her findings explored the demands of psychology training, self-doubt in trainees and the impact of training on the trainee and their significant relationships. Burnout was characterised by perseverance with difficulty rather than an inability to function. Participants developed greater resilience and improved self-monitoring following their experience of burnout.

Crim (2013) explored the experience of burnout in licensed alcohol and drug counsellors, with a specific focus on the causes of burnout and their coping strategies. Crim (2013) found that the sources of burnout included the interpersonal and occupational stress of working with clients, stress in their personal lives and organisational factors in their working environment. Crim's (2013) research also showed that counsellors employed a variety of strategies in order to cope with burnout, including taking time off, making use of clinical supervision, personal therapy, relaxation techniques and implementing boundaries in their work.

Petker (2016) highlighted the importance of self-care in maintaining professional competence and preventing burnout in novice counsellors. Her study elicited two main themes: the layers of self-care and the challenges of self-care. Petker's (2016) research found that self-care was not static and was, in fact, a fluid process comprising several layers. In addition, certain challenges to self-care emerged, such as transitions from being a student to a paid employee. Petker's (2016) study highlights the benefits of IPA research in the nuanced descriptions of self-care.

The findings of the above studies are specific to context and show us how important context is in the lived experience of burnout. Although these studies have provided valuable insight into the lived experience of burnout, a review of the literature revealed that research done using IPA was largely Doctoral and Master's theses and very few were published, peer-reviewed

literature. This indicated a need for further published, peer-reviewed studies into this specific area of burnout. In addition, none of the existing IPA studies' sample population consisted of qualified psychologists, focusing instead on the experiences of healthcare professionals (Volpato et al., 2018), substance use counsellors (Crim, 2013), novice counsellors (Petker, 2016), marriage therapists (Razo, 2018), trainee psychologists (Archer, 2020) and lay persons working in the field of mental health (Moodley, 2009).

2.10 Conclusion

A review of the literature explored the prevalence of burnout, the process and impact of burnout, coping strategies and help-seeking behaviours in dealing with burnout, and barriers to help-seeking, and concluded in a review of Interpretative Phenomenological Analysis. Research has demonstrated that burnout affects psychologists in a wide range of areas and, given the importance of the psychologist in the psychotherapeutic process, it is important to understand how burnout affects the therapist. The review revealed that despite the abundance of quantitative literature on burnout, the research on psychological implications of burnout, effective coping mechanisms for psychologists and barriers specific to burnout is lacking. The review of burnout literature also revealed a dearth of engagement with psychologists' in-depth, lived experiences of burnout. This is a particular concern within the South African context, whereby literature frequently engages with notions of burnout conceptualised outside of this specific context.

3 RATIONALE AND RESEARCH AIMS

3.1 Statement of the problem & study aims

Burnout has become an increasing concern for the working population as a whole (Glint, 2020). Research has demonstrated that burnout is highly prevalent amongst psychologists (Jordaan, et al., 2007a&b; Fourie, 2004; Metz, 1987; Philip, 2004; Simionato & Simpson, 2018; Smith, 1998). Psychologists and other mental healthcare practitioners are thought to be at particular risk for burnout due to the nature of the profession and the demands of helping others (Bakker, Demerouti & Sanz-Vergel, 2014). Although burnout appears to have been examined at length in terms of antecedents, symptomatology and management strategies (Ackerley et al., 1988; Huberty & Huebner, 1988; Lee et al., 2011; Huebner, 1992; Huebner 1993; Huebner 1994; Raquepaw & Miller, 1989; Rupert & Morgan, 2005; Sandoval, 1993; Simionato & Simpson, 2018) several gaps in the literature have been noted. Previous research has not explored the psychological implications of burnout thoroughly and have attempted to group psychological symptoms into broad concepts rather than exploring them idiographically. In addition, the management strategies proposed in literature are not completely effective, or are not implemented, indicated by the increasing rates of burnout among professionals. One then needs to consider why this is so, however, barriers to help-seeking have predominantly been explored in relation to mental illness and have not focused on burnout.

Popular models of burnout comprise concepts such as emotional exhaustion, emotional depletion, secondary trauma, compassion fatigue, cynicism, depersonalisation and reduced self-efficacy (Freudenberger, 1974; Maslach & Jackson, 1979; Maslach & Jackson, 1986; Maslach, Jackson, & Leiter, 1996; Maslach & Leiter, 2007; Schaufeli & Taris, 2005; Skovholt, 2012; Stamm, 2009; Stamm, 2010). However, these concepts and existing models failed to capture the rich, subjective experience of burnout, indicating a possible need for expansion. In addition, these models have been conceived primarily in first world countries and may not be entirely applicable to the developing country contexts.

The current body of literature on burnout is predominantly quantitative and there is a paucity of qualitative research that examines the lived experience of burnout (Simionato & Simpson, 2018). Of these qualitative studies, fewer still have been conducted within the framework of IPA. When studying a multi-faceted and nuanced concept such as burnout, it is valuable to explore the individual experiences of the phenomenon rather than endeavouring to find

universal explanations. On review of the literature, it was also noted that no research has been done on the lived experience of registered psychologists in the context of South Africa. Literature indicated that the South African context brings with it significant implications for psychological practice, therefore a detailed exploration of the phenomenon was required.

At present, the literature focuses on burnout in accordance with a series of dependent and independent variables. Current research superficially engages with psychologists' experiences and does so devoid of an embedded understanding within the psychologists' context. Thus, the present study aimed to augment previous burnout literature through exploring psychologists' subjective experiences of burnout. Through providing contextualised, lived understandings of the phenomenon, the present study seeks to deepen current conceptualisations of burnout within the South African context. Moreover, by engaging with the South African context, the present study elicits how aspects such as poverty, apartheid, and structural and organisational factors within the South African setting (or the culmination of these factors) impact on South African psychologists' perceptions of burnout. Within the South African setting, context cannot be devoid of our socio-political history and the influence of culture. By introducing new perspectives and allowing a deeper understanding, this study contributes to enriching the body of literature that is predominantly quantitative (Smith, 1996).

3.2 Research questions

An IPA study focuses on participants' experiences, understandings, perceptions or views on particular phenomena and aims to produce a detailed account and interpretation of a personal, human experience. Research questions therefore centred on understandings of psychologists' experience, how they make sense of their experience, and, on a larger scale, how they make sense of the world (Smith et al., 2009).

The research questions of the study are as follows:

1. How do psychologists describe their experience of burnout?
    - What are the perceived risk factors for burnout?
    - How do participants make sense of the process of burnout?

2. What are the perceived consequences of burnout?
    - What are the perceived physiological, psychological and occupational impacts?
    - What is their understanding of the impact on their home life?

- How do they view and understand their help-seeking behaviours?

3. How do they perceive their experience of burnout in South Africa?
    - How does their particular context influence their experience?

3.3 Conclusion

The purpose of this study was to examine the experience of burnout among psychologists. Although the prevalence of burnout has been studied extensively, research has thus far failed to unveil a meaningful understanding of the experience. Burnout is a complex concept and requires thorough exploration through various forms of research. The experience of burnout is likely to be subjectively experienced and interpreted, thus, this study seeks to explore the phenomena of burnout among psychologists in South Africa within the IPA framework in order to gain a deeper understanding of the experience and enrich the current body of knowledge that is predominantly quantitative.

4 THEORETICAL FRAMEWORK

4.1 Phenomenology: Theoretical Foundations

Given the exploratory nature of the present study, a phenomenological theoretical approach embedded within an IPA methodological framework was deemed most appropriate. Phenomenology is primarily a philosophical approach and is concerned with the human experience (Smith et al., 2009). Four key philosophers contributed to the field of phenomenology: Husserl, Heidegger, Merleau-Ponty and Sarte. Each of these philosophers contributed in different ways but all were primarily focused on the human experience.

4.1.1 Husserl

Husserl was regarded as a descriptive phenomenologist. His aim was to describe a lived experience without attempting to interpret or ascribe meaning to it. Husserl adopted a 'phenomenological attitude' that required one to be reflexive and focus on one's own perception of experience (Smith et al., 2009, p. 16). Husserl also developed the idea of needing to 'bracket' one's own pre-conceptions and values. This involved becoming aware of one's experiences, biases and attitudes and putting them to one side in order to see more clearly how one perceives a phenomenon (Smith et al., 2009, p. 17). These concepts put forward by Husserl were influential in phenomenological research, including IPA.

4.1.2 Heidegger

Whereas Husserl was focused on perception, awareness and consciousness, Heidegger concerned himself with existential questions and how the world was made meaningful to humans (Smith et al., 2009). Of importance to the IPA approach was Heidegger's view of a person as 'person-in-context', meaning that they cannot be understood outside of their context. Heidegger also disagreed with Husserl's concept of bracketing or removing one's personal beliefs, attitudes and values from the research process. Heidegger believed that a researcher cannot remove themselves from the research (Smith et al., 2009).

4.1.3 Merleau-Ponty

Merleau-Ponty contradicted Husserl's assumptions stating that one could clearly see the experience of another, stating that while one could observe another's experience, one can never share the other's experience entirely. In qualitative research and, more specifically,

phenomenological research, this view is critical and shapes the way we understand knowledge (Smith et al., 2009). Merleau-Ponty acknowledged that all perceptions and interpretations were made through the researcher's own perspective.

4.1.4 Sarte

Sarte extended existential phenomenology from Heidegger's work. Sarte saw meaning-making as an active process of engaging with the world in which we inhabit. Sarte also emphasised the importance of context, personal and social relationships, believing that experience was influenced by these contextual factors (Smith et al., 2009). Through the work of these four phenomenologists, experience can be understood as a lived process made up of perspectives and meaning unique to the individual. How they are situated in relationships and, more broadly, the world, cannot be separated from their lived experience (Smith et al., 2009).

4.2 Rationale for Phenomenology as a theoretical framework

Phenomenology attempts to describe the essence of human experience while setting aside existing theory in order to explore the phenomenon from a new perspective. Phenomenology aims to be true to the phenomenon and the context in which it occurs rather than reducing the phenomenon to a set of variables and attempting to manipulate the context to occur in a specific setting (Giorgi & Giorgi, 2008). Viewing the present study through an interpretive phenomenological lens allows the researcher to broadly explore the experience of burnout without the preconceptions and boundaries of existing theories. This allows for the researcher to explore, describe and interpret the lived experience of a phenomena in her/his own terms, rather than those prescribed by existing theoretical assumptions (Smith et al., 2009). In order to explore a specific phenomenon, phenomenology focuses on gathering first-hand descriptions of the individuals' experiences of the phenomenon (Giorgi & Giorgi, 2008). In the same vein, demand characteristics espoused when employing structured, quantitative measurements are avoided as the participants drive the interview process. Phenomena are usually experienced subjectively, thus the phenomenological theoretical framework assisted to produce unique, nuanced and valuable new insights into the phenomenon of burnout in psychologists in South Africa.

5 RESEARCH METHODOLOGY

5.1 Methodological Framework

This study seeks to explore the experience of burnout among psychologists in South Africa within the Interpretative Phenomenological Analysis (IPA) methodological framework. By using this framework, the present study seeks to understand how psychologists describe their experience of burnout, what the perceived consequences of burnout are and how the South African context influences their experience.

IPA draws on the theoretical orientations of phenomenology, hermeneutics and ideography (Pietkiewicz & Smith, 2012; Smith, Flowers & Larkin, 2009). Although IPA is included under phenomenology, it differs in that it does not advocate for the researcher to bracket his or her experience during research. IPA acknowledges that participants make sense of an experience, and the researcher interprets the participants' interpretations of the experience. The researcher's experience and interpretations therefore become part of the study findings instead of being bracketed separately; this adds another explanation or layer to the phenomenon under study (Matua & Van Der Wal, 2015). The findings in an IPA study present individual and unique perceptions in addition to common themes and shared experiences (Smith, 2004).

Studies using this framework focus on how individuals create meaning from their life experiences. Data comprises of detailed personal accounts of an experience or phenomenon. The researcher tries to understand what it is like to be in the participant's shoes whilst acknowledging that this is never truly possible (Pietkiewicz & Smith, 2012). Through interpretation, the researcher attempts to 'translate' the meaning of the phenomena to make it understandable to others (Pietkiewicz & Smith, 2012). The researcher plays an active role in the research, influencing the extent to which they gain access to the participant's world and how the world is made sense of through the researcher's own interpretation (Pietkiewicz & Smith, 2012). In IPA, generic experiential themes are presented and these are typically combined with the researcher's own interpretation of the data. This method of dual interpretation is also known as double hermeneutics (Pietkiewicz & Smith, 2012).

This study was conducted within the IPA framework and thus focused on how individuals make sense of their own world, how they experienced the phenomena of burnout and what meaning each individual placed on the phenomena. The research aimed to produce rich descriptions of the phenomena under study (Pietkiewicz & Smith, 2012). A methodological

framework includes theoretical foundations and recommendations for research design, including the most suitable sample, methods of data collection and analysis (Pietkiewicz & Smith, 2012). The way in which the IPA framework was applied to each step of the research process is described below.

5.2 Sample

5.2.1 Size

Samples in IPA are typically small in order for the researcher to conduct a detailed and time-consuming analysis of each case (Pietkiewicz & Smith, 2012). The researcher sought to collect rich, detailed data and provide a comprehensive analysis of each participant's experience of burnout, thus six participants were selected using purposive sampling. This method of sampling aligned with IPA framework recommendations and allowed the researcher to select participants for whom the research problem has relevance and personal significance (Pietkiewicz & Smith, 2012). A sample of six participants was considered a sufficient size for the researcher to analyse similarities and differences between the participants' experience, yet small enough to prevent the data becoming overwhelming to analyse (Pietkiewicz & Smith, 2012).

5.2.2 Tools used to screen potential participants

The Professional Quality of Life Scale version 5 (ProQOL; Stamm, 2009) was chosen to screen potential participants for burnout. The ProQOL is a 30-item scale used to measure compassion satisfaction and compassion fatigue in one's professional life. It is the most commonly used measure of the positive and negatives of working with distressed individuals and is frequently used in research (Stamm, 2010). The scale was originally designed to measure compassion satisfaction and fatigue in therapists. According to Stamm (2010), the professional quality of life is influenced by the work environment, client environment and personal environment. The ProQOL scale is made up of 3 sub-scales: (1) compassion satisfaction; (2) burnout; and (3) secondary traumatic stress (Stamm, 2009).

Compassion satisfaction relates to the pleasure experienced from one's work such as feeling that one is contributing positively by doing their work and feeling positively towards one's colleagues. According to Stamm (2009), burnout is an element of compassion fatigue and is associated with feelings of hopelessness and an inability to do one's job effectively. These feelings build up gradually. The second element of compassion fatigue, according to Stamm

(2009), is secondary traumatic stress. Secondary traumatic stress occurs after being vicariously exposed to traumatic events. This may happen when one is repeatedly exposed to traumatic events, as is often the case in most therapy work. The scoring system gives indications of the participant's burnout level (low, average, high) in each sub-scale (Stamm, 2009).

Although the ProQOL is not without critique (Hagan, 2020; Maila, Martin & Chipps, 2020), it was deemed appropriate for use by the author as a screening tool to establish whether potential participants have experienced burnout. The decision was made to use the ProQOL rather than more commonly-used measures such as the MBI as the need was for a simple, quick, screening tool to establish presence of burnout in the past 24 months. In this way the ProQOL was deemed more appropriate than the MBI. No statistics were elucidated from the ProQOL, thus the measure's level of reliability and validity were deemed fit for purpose. The ProQOL is free to use and was available for download from the ProQOL website.

5.2.3 Inclusion criteria

Inclusion criteria for the sample were as follows: psychologists must be registered with the HPCSA in the Clinical or Counselling Psychology fields of practice; the participants' race, gender and experience in the field was considered while sampling in an effort to diversify the sample; and there was no limit set for years in practice or practice setting. Participants in the present study were required to have experienced burnout within the past 24 months to ensure rich narratives and adequate recall of burnout experiences during the semi-structured interviews. Participants who scored average or high in either/both the burnout sub-scale and the secondary traumatic stress sub-scale were asked to consent to participation and formed part of the sample. Presence of burnout was measured using the ProQOL scale (Stamm, 2009) (See Appendix B attached). Sampling continued until the required number of participants was reached. The sample was relatively homogenous, as recommended in the IPA framework, in terms of profession, tertiary studies, socioeconomic status and country of practice. All participants were living and practising in South Africa and had undergone the minimum required tertiary study and internship to become a registered psychologist.

Table of participant demographics

Participant no.	Pseudonym	Race	Gender	Field of practice	Age group (years)
1	Susan	White	Female	Counselling	40-60
2	Thabisile	Black	Female	Counselling	40-60
3	Brett	White	Male	Clinical	20-40
4	Maria	White	Female	Counselling	40-60
5	Zinhle	Black	Female	Clinical	20-40
6	Lerato	Black	Female	Counselling	20-40

5.2.4 Sampling Procedure

A convenience sample from the Durban Practising Psychologists Group Directory was initially contacted, via email, to enquire about their willingness to participate in the study. The email contained, amongst other things, a short description of the study's aims and methodology. Those psychologists who agreed to participate were asked to complete the ProQOL questionnaire to determine whether they meet the inclusion criteria. Those who met the inclusion criteria and consented to participation thereafter formed part of the sample. A snowballing procedure was employed whereby study participants were asked to refer other possible candidates. No gatekeeper access was required in this research. The consent and assent to be included in the research study was obtained from each psychologist individually. Each participant was briefed on the risks and benefits of the study and was required to read and sign acknowledgement of informed consent.

A total of 9 potential participants were initially sampled. Of those 9, one did not meet the inclusion criteria due to low scores on both the burnout and secondary stress inventory, and two failed to complete the ProQOL questionnaire. Sampling continued until 6 participants met the inclusion criteria and agreed to continue with the study.

Potential Participant ProQOL Screening Scores

	Burnout Score	Secondary stress score
Potential Participant 1	38 (Average)	20 (Low)
Potential Participant 2	20 (Low)	23 (Average)
Potential Participant 3	24 (Average)	15 (Low)
Potential Participant 4	n/a (ProQOL not completed)	n/a (ProQOL not completed)
Potential Participant 5	n/a (ProQOL not completed)	n/a (ProQOL not completed)
Potential Participant 6	23 (Average)	16 (Low)
Potential Participant 7	23 (Average)	14 (Low)
Potential Participant 8	15 (Low)	18 (Low)
Potential Participant 9	28 (Average)	25 (Average)

5.3 Data Collection

5.3.1 Interview protocol

Semi-structured, in-depth, one-on-one interviews were used to collect rich, detailed accounts of the participants' experiences. Psychologists were interviewed for approximately 1 hour by the researcher. The participants were asked the open-ended questions contained in the interview schedule (See appendix C). Prompts were prepared beforehand and were used when participants needed encouragement to elaborate. Data was collected in natural settings (the psychologist's home or place of work). The interviews were audio-recorded and then transcribed by the researcher at a semantic level. All the words spoken, including significant pauses, laughs and other important features, were transcribed as per IPA recommendations (Smith et al., 2009).

5.3.2 Semi-structured interviews

Semi-structured interviews allowed the researcher and participant to engage naturally on a topic while allowing the space and flexibility for unexpected topics to arise and be included in the discussion (Pietkiewicz & Smith, 2012).

5.3.3 Interview schedule

Each interview began by giving a summary of the purpose of the research and allowing time for the participant to ask questions before starting. The participant was first asked to tell the researcher about a time when they experienced burnout or what they perceived to be burnout. The researcher focused during this time on listening carefully with empathetic presence and engaged in minimal probing. This allowed the researcher to build rapport with the interviewee, reduce the interviewee's anxieties about the interview and made him/her comfortable to discuss personal or sensitive matters should they arise (Pietkiewicz & Smith, 2012). An interview schedule was prepared in advance (See appendix C). This plan contained key questions or topics to be discussed (Pietkiewicz & Smith, 2012). Most of the questions were open-ended, designed to encourage participants to talk freely and at length. The researcher then used tactical probing to encourage the interviewee to explore deeper into their experiences and facilitate more meaningful discussion.

5.4 Data Analysis

The IPA framework does not prescribe a single method of data analysis. IPA involves a line-by-line analysis of the data, searching for themes and sub-themes and trying to ascertain the meaning behind participants' experiences (Smith, Flowers & Larkin, 2009). Analysis in IPA is an iterative and cyclical process (Smith, Flowers & Larkin, 2009) and requires flexible engagement with the data, creativity and revision. Thus, analysis is open to change and revision and patterns emerge and are identified as each subsequent case is analysed (Smith et al., 2009).

As per the IPA framework, the researcher began by reading and re-reading the data, immersing herself in the participant's world without making notes or interpretations. This initial reading allowed the researcher to gain an overview of each interview, alerting the researcher to more detailed sections of data, contradictions and anything else that initially stood out (Smith et al., 2009). After reading, the researcher made initial notes. This part of the analysis was both detailed and time-consuming. Exploratory notes and comments were added with each reading of the transcript. The researcher also noted key areas of concern (Smith et al., 2009), particularly those relating to the research questions. After initial notes were made, the researcher made descriptive comments making note of key words, phrases and explanations given by the participant. The researcher subsequently developed emergent themes by analysing the exploratory notes made in the previous step. This was done in an effort to reduce the volume

of data and provide focus without losing the complexity of the data. The themes were then laid out in the order that they appeared in the data (Smith et al., 2009). The next step in the analysis process was to look for connections across themes, i.e., how the themes fit together. At this point, some themes were judged to be less relevant and discarded. After this process the researcher began the same process on the next case. (Smith et al., 2009). After all transcripts were analysed, and initial themes were identified, the themes were grouped together into over-arching, super-ordinate themes. The themes identified are introduced in Chapter 6

When forming the discussion in IPA research, it is important to have identified the important constructs in burnout literature in order to compare the understandings of participants to the constructs in literature. This must be done with caution during interpretation and analysis of the data (Smith et al., 2009). During the discussion the researcher makes connections between their data analysis, their own personal and professional experience and the findings of existing literature on the phenomenon under study.

5.5 Validity and trustworthiness in qualitative research

In qualitative research it is important to acknowledge that knowledge and experience are not objective and are shaped by one's subjective reality (Yardley, 2000). There is therefore no one ultimate truth that trumps all others. It is for this reason that it is difficult to prove the validity and trustworthiness of qualitative data in the same way as quantitative research. Morrow (2005) however, states that the foundations on which a paradigm is built informs the criteria for trustworthiness in qualitative research (Morrow, 2005). Sufficiency of, and immersion in, the data, attention to reflexivity, adequacy of the data and interpretation and presentation of the findings are important to consider in any paradigm (Morrow, 2005), particularly in interpretative research. Although IPA analysis is subjective in nature, there are ways of demonstrating validity and trustworthiness. Guba and Lincoln (1994) outline four important domains to establish trustworthiness in qualitative research: credibility, transferability dependability and confirmability. These domains are applicable to IPA studies (Morrow, 2007).

5.5.1 Credibility

One of the most important ways of establishing trustworthiness in qualitative research is by ensuring credibility (Guba and Lincoln, 1994). Credibility establishes how congruent the study findings are with reality (Merriam, 1998). In order to achieve credibility, it is important for the

researcher use well-established research methods. In the present study, the researcher chose to use the IPA framework as literature has shown it to be well-suited to the study of experience.

In IPA research, credibility pertains to the provision of a thick description and deep understanding of the lived experience of participants in a specific context (Morrow, 2005). In the present study, the participants were allowed to speak broadly about their experiences and were guided by open-ended questions in the interview in order to facilitate this. A non-judgemental attitude and an empathic presence was adopted by the researcher in a bid to facilitate open and honest reflection by participants.

The present study took on an interpretivist stance to phenomenology, as per IPA, and explores meaning through interpretation, discussion and reflection. Although the researcher must interpret the interpretations of the participants, the participant is still considered the expert of their own experience in IPA (Smith et al., 2009). Experience is embedded within social and historical context. The double hermeneutic stance of IPA allows a more objective view of the data and it is not simply interpreted by the person embedded in the context but by the researcher who may have a different or outsider view (Matua & Van der Wal, 2015; Van der Riet, 2008). This enhances the credibility of the study findings.

5.5.2 Transferability

Transferability relates to external validity (Merriam, 1998) and generalisability (Shenton, 2004), in other words, it is the extent to which the findings of a study can be applied to other situations. Erlandson et al. (1993) argue that even in positivistic research, complete generalisability is not possible as all observations are influenced by the context in which they occur. Although idiographic in nature, an effective IPA study should shed light on the phenomena in a broader context (Smith et al., 2009). Pitts (1994) states that it is a gradual process to understand a phenomenon and thus an isolated study should not be regarded as a complete understanding of it. The present study acknowledges that further research is needed in order to completely understand the phenomenon of burnout in South African psychologists.

In order to facilitate transferability in the present study, the researcher has included detailed reporting of the sample, sampling procedure, methods of data collection and analysis (Silverman, 2005), as well as the specific context in which the research was conducted.

5.5.3 Dependability

Shenton (2004) compares the concept of dependability to reliability in quantitative research. Unlike quantitative research, it is not possible to repeat a study in the exact same context, with the same participants and methods. According to Florio-Ruane (1991), one method of ensuring dependability is to first ensure credibility. Another method is to report all research processes in detail in order for other researchers to assess whether proper research practices have been followed. In addition, researcher bias can be reduced by keeping an audit trail of the research process (Gasson, 2004). The researcher of the present study kept a detailed record of the sampling procedures, data collection and analysis during the research process in order to ensure dependability. These are reported in Chapter 5.

5.5.4 Confirmability

Morrow (2007) states that confirmability in qualitative research is comparable to objectivity in quantitative research. It is important that, as far as possible, research findings reflect the experience of the participants and not those of the researcher (Shenton, 2004). Confirmability in the present study was facilitated by the researcher engaging in critical reflection throughout the research process. Subjectivity cannot be separated from qualitative research, therefore, the researcher's subjective position must be made known in the study (Holt, 2003).

5.5.5 Researcher subjectivity

Interactions between the researcher and participant in qualitative research are of great importance in that they mimic the client-clinician relationship in clinical practice (Yardley, 2000). Due to the importance of the interaction, personal issues may influence the validity of the research. It is thus important for the researcher to become aware of their own implicit assumptions and biases, make them overt to oneself and others and then put them aside while conducting research to reduce the influence they have over the research (Husserl, 1931 cited in Morrow, 2005). In IPA it is acknowledged that putting one's assumptions and biases completely aside is impossible. It is also acknowledged that one's inherent bias may only make itself known during the research process. Thus, reflective engagement is essential in IPA (Smith et al., 2009).

In an IPA study, analysis is a collaboration between the participant and the researcher (Smith et al., 2009). During the process of analysis, both the participants' and researcher's

interpretation of the burnout phenomena was considered (Pietkiewicz & Smith, 2012). Although the meaning that the participants place on their experience is of primary concern, the end result of the analysis is always an interpretation by the researcher of how he/she thinks the participant is thinking (Smith et al., 2009). Hermeneutics and phenomenology acknowledge that there is no such thing as an "uninterpreted phenomenon" (Pietkiewicz & Smith, 2012, p. 363). Thus, during analysis, it was important for the researcher to maintain epistemological reflexivity. Reflexivity refers to the researcher asking critical questions such as "How does the research question define and limit what can be found? If the research problem were defined differently, how would this affect the understanding of the phenomenon under investigation?" (Willig, 2008 cited in Pietkiewicz & Smith, 2012, p. 361). In addition, the researcher made note of any preconceptions prior to the research process and reflected throughout the study on her feelings and thoughts towards the participants and their experiences. The researcher's reflections are described in detail below.

5.6 Author reflections

Morrow (2005) emphasises the importance of qualitative researchers being aware and reflexive about their personal bias, prejudices and assumptions. Reflection on how one's life experiences, beliefs and values may affect the researcher process is essential (Willig, 2013 cited in Archer, 2020). IPA research highlights the importance of reflexivity due to the interpretivist nature of the framework. A personal reflection of the present study's author is therefore presented below.

As an intern clinical psychologist, my perceptions of burnout were influenced by my clinical training in addition to witnessing burnout in my colleagues. My experiences, values and beliefs about burnout thus impact on how I perceive the phenomena and how I interpret the experiences of my participants.

Burnout in clients is typically diagnosed and treated by psychologists. I was therefore interested in what occurs when burnout is experienced by the professional. I began this study wondering how psychologists' experience burnout and what their perceptions of it were from a psychologist's standpoint. While reviewing the literature, I found that mental illness was often stigmatised by the health professionals responsible for treating it. I was surprised that the very people who are supposed to treat mental illness and advocate for those who are ill, would hold prejudice towards those they treat. I wondered then about the impact of stigma on burnout and

how that would be perceived by psychologists, especially when they are experiencing it themselves.

Prior to immersing myself in this study, I viewed burnout as a negative experience and I did not consider the positive implications. While navigating the research, I noticed that I held some judgement towards psychologists in private practice who experienced perpetual burnout. I blamed them for not managing their burnout effectively and believed they preferred to hold onto their burnout as a 'badge of honour'. The majority of my colleagues who experienced burnout worked in a public healthcare setting where there was very little control over their working hours, how many patients they saw and the kind of cases they took on. Therefore, I noticed a small part of me blamed private practitioners for not being able to prevent burnout despite these factors being within their control. I did not account for the 'need to do more' and self-sacrifice that appears inherent in many psychologists.

Although I wished to examine the experience of burnout from the context of South Africa, I neglected to facilitate a thorough discussion around race and history, despite these being significant factors in the South African context. This points a possible blind spot where my stance as a privileged, white, female may have led me to overlook the importance of these factors in shaping the experience. On further reflection, I realised I perceived all psychologists to be homogenous in that they are of similar socioeconomic status and are united by the work they do, however, this is not so, and a black psychologist may have a very different experience to a white psychologist, particularly in South Africa where historical inequities and post-apartheid dynamics are still very much present in today's society.

5.7 Ethical considerations

Due to the importance and reciprocal nature of the researcher-participant relationship in qualitative research, ethical issues must be considered carefully. Consideration for the four key principles of ethics, namely: autonomy and respect for the dignity of persons, non-maleficence, beneficence and justice, was kept in mind at all times throughout the present study (Wassenaar, 2006).

Allmark et al., (2009) reviewed the ethical issues related to in-depth interviews. The researchers noted that the emotionally intense nature of in-depth interviews exposes the participants to possible harm, particularly if the topic is of a sensitive nature. Despite this,

Allmark et al. (2009) reported that participants are not averse to discussing difficult issues if they thought the study was worthwhile.

Due to the nature of IPA studies, it was important for the researcher to be cognisant of the interviewee during the interview. The researcher made use of counselling skills in order to contain and reassure the interviewee if needed. It was kept in mind at all times that if the issue is above the researcher's level of competence the session would be stopped, and the interviewee referred to appropriate professional psychological care (Pietkiewicz & Smith, 2012).

The autonomy of participants was protected throughout the process of the study. Participants were made aware that there was no gain to be acquired by participating in the study, nor any negative consequences were they to choose not to participate, or should they choose to withdraw at any time. Social stigmatisation was prevented by maintaining confidentiality of all participants at all times by protecting personal and clinical information. Participants' names or addresses were not recorded at any point in this study. In order to ensure anonymity, pseudonyms were used in place of participants' names. Each participant was given the opportunity to debrief at the end of the interview. This was optional and participants had the right to refuse. Participants were notified that if they experienced any form of psychological distress resulting from participation in this research, they would be referred to the UKZN Psychology Clinic or another suitable psychological service.

5.8 Storage and Disposal of Research Data

Research data was kept in a locked filing cabinet during the research process and will remain there for a period of 5 years. Audio recordings were deleted immediately after transcription in order to protect the participants' anonymity and eliminate the likelihood of them being identified by their voice. After the 5th year, the hard copies of the transcriptions will be shredded and the softcopies will be deleted. The research supervisor obtained and stored copies of all transcribed research work.

6 FINDINGS

6.1 Summary of each participant's experience

The purpose of this study was the explore the experience of burnout among registered psychologists in South Africa. Six participants were asked to explore their in-depth experience of burnout, their perception of the phenomena and what meaning they ascribed to the process of burnout. They were asked to engage with an experience of burnout, the potential antecedents, barriers to help-seeking, impact of burnout and how the South African context may have shaped their experience of burnout.

Before the themes that emerged from the data are discussed, a 'picture' of each participant is presented in order to provide context for further discussion in the themes. Each participant's experience is summarised and the impression they gave to the author is mentioned where applicable.

6.1.1 Susan

Susan initially appeared open to discussing her experience of burnout, however, she later appeared visibly embarrassed about some of the information she relayed and frequently used humour defensively. Despite this, she did not appear to consciously filter her responses and was emotionally vulnerable when retelling her experience. Based on Susan's narratives, she appeared to be perfectionistic by nature. This tendency is thought to be exacerbated when she is experiencing burnout. Susan appeared to engage in unconscious defence mechanisms and initially denied that she experienced compassion fatigue. It was more difficult for her to admit she experienced reduced empathy than any other 'symptom' of burnout. Susan's experiences of burnout were associated with shame. She berated herself both for her decline in functionality and her inability to manage her burnout effectively. Susan felt overwhelmed and helpless by her experience of burnout as her self-care strategies were not effective in the alleviation of burnout symptoms. In her practice, Susan frequently delivers trauma psychotherapy. She verbalised the prevalence of vicarious traumatisation in South African psychologists' given the high levels of trauma in society. Accordingly, Susan noted that, South African psychologists may be predisposed to high levels of anxiety prior to commencement in the therapeutic relationship.

6.1.2 Thabisile

My impression of Thabisile was that she was frank and candid about her experience. She did not attempt to 'sugar coat' her reflections. In contrast to other participants, Thabisile openly verbalised her experience of compassion fatigue. Notwithstanding her openness regarding compassion fatigue, Thabisile appeared to admonish herself upon realisation that she wasn't fully present with her client and was not delivering high-quality service. It is likely that the loss of compassion bothered her more than she acknowledged, and it appeared that she used humour to mask her vulnerabilities in this area. Thabisile appeared independent and relatively asocial by nature. When experiencing burnout, Thabisile's tendency to withdraw appears to worsen and she avoids social interactions. Thabisile believed that working in a South African context brought about a higher caseload and increased trauma cases, however she felt that South African psychologists were resilient to trauma as they had acclimatised to the violence of South African society. She appeared to prefer delivering trauma psychotherapy when she is burnt out as there was usually defined therapeutic goals and measurable improvement which provided her with a sense of achievement.

6.1.3 Brett

Brett is comparatively young and less experienced than the other participants. His experience of burnout seemed to start in his internship and carried through, to a lesser degree, after he became a registered psychologist. Brett experienced changes in his emotional state that were initially noted by his romantic partner. Brett emphasised his use of various protective strategies in managing his burnout. He noted that he did not define his identity through his psychological work and thus was more able to maintain a work-life balance. On reflection, Brett noted that his strong sense of identity was an important protective factor. When he initially experienced burnout, he was not able to engage reflexively and he questioned his career path as a psychologist. Brett appeared to have become more aware of his own internal resilience as a result of his experience of burnout. My impression was that, overall, it was a valuable learning experience for him, and he was able to draw from the experience.

6.1.4 Maria

Maria appeared somewhat guarded and/or unaware of her potential burnout experiences. My impression of Maria was that she is an energetic individual who thrives within a busy environment. It appeared important to her that she is needed by others, and she ensures she is

needed by performing tasks. While this energy may be protective, it could also lead her to not fully acknowledge early burnout symptoms. Maria noted that within her childhood she was socialised into a caretaking role, and this shows strongly throughout her responses. Maria stated that in her belief there was no stigma around burnout in the psychological profession. In addition, she spoke somewhat idealistically about how supportive the profession was in regard to burnout. This may be linked her own inability to acknowledge that she was burnt out.

6.1.5 Zinhle

Zinhle appeared somewhat guarded about her experience of burnout. Although she admitted she was feeling chronically exhausted and felt relieved when clients cancelled their sessions, she struggled to label these feelings as burnout. She initially stated that she didn't think what she had experienced was burnout, however through talking more about her experience she later noted that she was struggling to call it burnout. Zinhle's appeared to take on a higher caseload than she was capable of, due to a sense of duty to her clients and colleagues. When she failed to meet the standard of service quality, she believed she should be providing, she worked harder. Zinhle also appeared to struggle with being boundaried with her time and often spent evenings and weekends working. Zinhle works in a clinical setting so this may be indicative of what other psychologists may experience in this context. Zinhle appeared to question the relevance and importance of her role as a psychologist in a country plagued with socioeconomic disparity.

6.1.6 Lerato

Lerato spoke at length about her experience of burnout and reflected on her need to 'debrief' from her experience, using the interview as a means to do so. Lerato had a slightly different experience of burnout than the other participants, in that she experienced traumatic incidents with clients and received little organisational support from her superiors. Her distress over the experience was captured by her use of emotive language and disjointed speech. Her experience of trauma was observed by her stunted sentence structure and her tendency to derail from current thoughts. Lerato spoke quickly and at length, and appeared to be processing what happened for the first time. Lerato's interview also highlighted the stigma related to burnout as it was clear she did not feel comfortable verbalising her experiences to superiors within the organisational setting. A primary finding from the interview with Lerato was her sense of resilience and continued effort to overcome burnout.

6.2 Emergent themes

The transcripts from each interview were analysed as per IPA methodology. The following themes initially emerged from the data: (1) Intellectualised description of burnout, (2) Emotion-laden description of burnout, (3) Expectations on themselves, (4) Guilt and self-blame, (5) Occupational impact, (6) Self-care, (7) Coping mechanisms, (8) Internal contributing factors, (9) External contributing factors, (10) Nature of psychological work is a risk, (11) Physiological impact, (12) Psychological impact, (13) Social impact, (14) Stigma, and (15) Insight and self-awareness. These themes are included in the table below.

Table of Emergent themes

Participant 1 - Susan	Participant 2 - Thabisile	Participant 3 - Brett
Intellectualised description	Intellectualised description	Intellectualised description
Nil	Nil	Listed diagnostic criteria Described it as impairment in function
Emotion-laden description	Emotion-laden description	Emotion-laden description
Mental exhaustion	No capacity left	Mental energy = Credit card Burnout = deficit in funds
Expectations of themselves	Expectations of themselves	Expectations of themselves
Needing to do more/give more Continue working despite burnout	Needing to do/give more Self-doubt	Needing to do more/give more
Guilt and self-blame	Guilt and self-blame	Guilt and self-blame
Linked to sense of self-competence If I'm burnt out, I'm not good enough	Not meeting expectations for level of care	Implied - not overt
Stigma	Stigma	Stigma
No significant stigma experienced Linked to expectations Some fear of judgement	No significant stigma experienced Linked to expectations	Linked to expectations Self-stigma
Occupational impact	Occupational impact	Occupational impact
Admin impaired Less active in therapy (initially said sessions not impacted) Apprehension prior to sessions	Less compassion Becomes solution-focused Missing things in session	Admin Lack of preparation for session
Social impact	Social impact	Social impact
Social withdrawal	Social withdrawal	Minor social impact
Psychological impact	Psychological impact	Psychological impact
Irritability Anxiety Emotional exhaustion Self-concept linked to performance Impairs self-competence	Irritability No apprehension Lacks compassion	Irritability Anxiety & obsessive Self-esteem Job must not be linked to identity Questioning self – is this who I am?
Physiological impact	Physiological impact	Physiological impact
Fatigue Headaches & muscle tension	Fatigue	Hypervigilance
Nature of the work is a risk	Nature of the work is a risk	Nature of the work is a risk
Nature of work is risk factor Certain types of clients Work environments	Nature of work is risk factor Certain types of clients more difficult	Nature of work is risk factor Certain types of clients Workload

Vicarious trauma		Vicarious trauma
Internal contributing factors	Internal contributing factors	Internal contributing factors
Performance is important Possible Neuroticism Need for control	Need for own containment (emotional dysregulation)	Internal resilience Carefree outlook on life Need for own containment ILOC vs. ELOC
External contributing factors	External contributing factors	External contributing factors
Financial stress	Nil	Loss of loved ones
Self-care	Self-care	Self-care
Self-care neglected	Need for self-care to be pre-emptive Belief that burnout avoidable Limits workload	Social support Self-awareness Self-care Collegial support protective
Coping mechanisms	Coping mechanisms	Coping mechanisms
Compartmentalisation Collegial support	Coping mechanisms	
Insight & self-awareness	Insight & self-awareness	Insight & self-awareness
Burnout is insidious	Burnout is insidious Insight has grown with experience Self-awareness is protective	Burnout is insidious Self-awareness is protective

Participant 4 - Maria	Participant 5 - Zinhle	Participant 6 - Lerato
Intellectualised description	Intellectualised description	Intellectualised description
Described it as impairment in areas of functioning	Performance not optimum	Nil
Emotion-laden description	Emotion-laden description	Emotion-laden description
Functioning is robotic – loss of vitality	Nil	Experience of drowning - helplessness
Expectations of themselves	Expectations of themselves	Expectations of themselves
Needing to do more/give more	Needing to do/give more Be superhuman Continue working despite burnout	'I have to do it' Need to hold it together, don't show it
Guilt and self-blame	Guilt and self-blame	Guilt and self-blame
Expectations of self not met Need to be useful Linked to expectations from others	Expectations not met Questioning role of psych in SA Linked to expectations from others	Feeling they could have done more
Stigma	Stigma	Stigma
No significant stigma experienced Burnout more stigmatised in other professions	Self-Stigma is unconscious	Stigma linked to expectations of therapists Leads to Questioning competence
Occupational impact	Occupational impact	Occupational impact
Action-orientated Less compassion Less patience	Admin Emotionally drained in session Relief when sessions cancelled	Questioning the career choice
Social impact	Social impact	Social impact
Nil	Minor social withdrawal	Social withdrawal
Psychological impact	Psychological impact	Psychological impact
Emotionally labile Irritable Performance & self-worth affected Work identity vs. real identity	Irritable Feeling overwhelmed Helplessness linked to SAn context	Addiction to energy drinks Self-doubt Defensive Work identity vs. real identity
Physiological impact	Physiological impact	Physiological impact
Fatigue	Fatigue Headaches	Fatigue Weight gain

		Hypervigilance Skin rashes
Nature of the work is a risk	Nature of the work is a risk	Nature of the work is a risk
Lack social support Certain types of clients Workload Vicarious traumatisation	Nature of the work Certain types of clients Workload Vicarious trauma	Nature of the work Types of cases (suicide) Workload Vicarious trauma
Internal contributing factors	Internal contributing factors	Internal contributing factors
Messages received from childhood 'Doing' linked to identity Struggle delegating Need for control	Performance is important 'Doing' linked to identity	Resilience Flexibility Firm boundaries
External contributing factors	External contributing factors	External contributing factors
Multiple roles Loss of loved ones External stressors	Multiple roles	Office politics Lack of social support
Self-care	Self-care	Self-care
Saying no – work balance Self-care Collegial support/peer supervision Social support	Self-care Self-monitoring	Self-care Coping mechanisms (suppression) Collegial support/peer supervision Therapists don't always reach out for help
Insight & self-awareness	Insight & self-awareness	Insight & self-awareness
Self-awareness is important Experience is protective Minimising experience	Insidious Did not attribute symptoms to burnout Lack of self-awareness	Self-awareness

6.3 Final themes

These emergent themes were then grouped into five superordinate themes: (1) description of burnout reflects inner experience, (2) idealised expectations of self; (3) multi-faceted impact of burnout; (4) risky business; and (5) self-protection: a lofty goal. These are included in the table below.

<u>Table of Final themes</u>

Superordinate themes	Themes	Sub-themes
Description of burnout reflects inner experience	Intellectualised description	Diagnostic criteria/textbook descriptions Removal of personal experience from description
	Emotion-laden description	Emotive language Robotic/drowning/nothing left to draw
Idealised expectations of self	Expectations of themselves	High expectations Criteria for what constitutes a good enough session High level of empathetic presence expected
	Guilt and self-blame	Internal attributions
	Stigma	Inherent Overt

Multi-faceted impact of burnout	Occupational impact	In session vs. out of session Compassion fatigue Impatience → move to solution focused
	Social impact	Social withdrawal
	Psychological impact	Emotionally labile Irritability and anxiety Negative self-talk and cognitive distortions Injury to self-concept
	Physiological	Chronic fatigue Hypervigilance Headaches, Weight gain
Risky business	Nature of psychological work is a risk	High levels of empathy required Vicarious trauma Taxing cases
	Internal contributing factors	Personality Need for own containment
	External contributing factors	Multiple roles Stressors
Self-protection: a lofty goal	Self-care	Diverse strategies Frequently neglected
	Coping mechanisms	Compartmentalisation Social withdrawal
	Insight & self-awareness	Burnout is insidious in nature Insight is delayed Ability to self-reflect is protective

6.4 Description of burnout reflects inner experience

Participants were asked to describe or define burnout in their own words. It was hoped by the author that they would either connect their own experience with their description or they would unconsciously project their own experience and perceptions in their description. This also gave them the opportunity to define their own experience of burnout devoid of the influence of prior research. There appeared to be a distinct split across participants in the language they used to describe burnout. Half of the participants described the phenomena in an intellectualised manner, devoid of personal connection or personal experience. It appears that the way participants described burnout was an authentic reflection of their inner experience and was in line with their overall perception of burnout (See Section 6.1).

Maria and Zinhle used intellectual descriptions of burnout. Intellectualisations of the phenomenon may be used in an unconsciously defensive manner given that both these participants denied experiences of burnout at the outset. It appears that the participants did not

truly know what burnout is and therefore they not only struggled to say whether they actually experienced burnout, but they were also unaware that they defended themselves against the experience. Although Maria and Zinhle described experiencing the symptoms of burnout as per academic literature, they were still hesitant to label it as burnout. Zinhle further used the phrase "my burnout, inverted commas", indicating that Zinhle did not personally believe she was experiencing burnout but that she would use the phrase for the purpose of the interview. These descriptions illustrate a hesitancy amongst participants to recognise their burnout experience and possibly indicate stigma surrounding burnout amongst the sample. While conveying their perception of burnout, they appeared divorced from their own experience of burnout. Although Maria disavowed burnout, she encapsulated the loss of vitality and passion associated with burnout by noting that:

> *…it's just sort of that robotic-like, 'Hello, is there anybody at home'. It is just a robotic plodding, get up in the morning, plod, plod, plod. There's no... there's lack of energy, there's no animation, there's no happiness, there's no joy, there's no passion, there's no... yeah. It's just all lost. Maybe some kind of impulsive behaviour that results in decision-making that is not necessarily thought out clearly enough, irrationality. (Maria)*

Susan, Thabisile and Lerato used emotion-laden words and descriptive analogies when describing burnout. These descriptions appeared more personal and are likely to be a more accurate reflection of their own experiences. Lerato's descriptions were characterised by overt feelings of being overwhelmed. She painted a picture of a person drowning, seeing a lifeline, and being unable to reach out and save herself.

> *The minute you feel like this is the worst that I've had to deal with, something else would actually come up. So knowing that, without fail, something worse is coming up …when we are talking about burnout is when we are drowning in whatever we are doing you cannot get yourself out of it... it will get you to a point where you are just outmatched in everything and then you cannot get out of it. (Lerato)*

Lerato's responses also conveyed a sense of dread in the way she describes knowing something worse is coming but being unable to avoid it. Her word 'outmatched' also gave the author an image of a sports team being sent onto the pitch to play the home favourites, knowing they were not good enough to defeat them. Her description captured the sense of helplessness she

experienced. Unlike the rest of the participants, Brett described burnout in both an intellectualised and an emotional way, possibly indicating a greater integration of his experience.

> *…that's exactly where burnout comes from when you're trying to draw that energy and it's just not there. It's like if I want to use the metaphor of using a credit card. You think you've got all this energy and you're just spending, and spending, and spending, but at some point, it's going to catch up with you, and I think that's exactly what burnout is because you don't necessarily realise it's going to hit you that hard, and then it does… (Brett)*

Brett's credit card analogy is a useful way to describe burnout. One can imagine Brett placing deposits of emotional energy into a bank, only to withdraw it until there is none left. This also highlights the importance of making 'deposits' in the form of self-care. The above descriptions indicate that participants employing personal, emotive descriptions of burnout had a greater awareness and acceptance of the phenomenon than participants describing burnout in an intellectualised manner.

6.5 Idealised Expectations of Self

All of the participants' responses reflected a perceived unrealistic standard in the psychology profession. From the participants' responses, this appears to stem predominantly from expectations psychologists place on themselves. Guilt and self-blame followed when they did not meet those expectations. Interestingly, their answers also reflected a self-imposed stigma against weakness, with many participants giving disparaging narratives related to burnout. Some participants also described experiencing stigma from other psychologists if they were unable meet the high standards of professional care. This theme is closely connected to the first theme 'Descriptions of burnout'. Because of unrealistic standards in the profession, some psychologists battle to be more vulnerable, thus intellectualising and disconnecting from their own experience. Psychologists are often put on a pedestal by themselves, the public and other professionals. They are expected to remain empathetic and energetic while seeing multiple people who are suffering emotionally and never experience their own internal dysregulation.

Most participants acknowledged the weight of responsibility they carry as psychologists and feeling the pressure to make a difference in clients' lives. Despite what may be happening in the session or in their personal lives, they appeared committed to delivering high quality

services. There appeared to be some form of implicit criteria for what constitutes a ‘good session’ or ‘good enough’ psychologist and most participants held themselves almost solely responsible for clients’ experiences in the therapy room. The participants felt guilty that they were not always able to give of their best to their clients when burnt out and felt they were somehow cheating their clients out of a better therapeutic experience.

> *…by the end of the session, I would have a horrible feeling like I didn't really achieve anything in this session because I didn't do my part well enough. (Susan)*

> *…thinking of those times where I actually needed to prepare and didn't prepare, I would then feel [pause] quite ashamed I suppose, guilty like I'm not doing my job to my best ability like I'm almost short-changing my clients… (Susan)*

Susan’s use of the word ‘short-changing’ points to the transactional nature of the therapeutic relationship. In her view, her clients weren’t getting what they were paying for when she wasn’t performing at her best.

Thabisile and Zinhle described feeling that they needed to take on more responsibility and to be a certain way as a therapist. This appeared to be linked to their expectations of themselves in their role as psychologists. Thabisile’s responses indicated that she has certain role expectations as a psychologist that extend into who she is as a person. For example, when she says she does not help people she is not herself. This points to the connectedness between a psychologist’s profession and personal identity.

> *I believe that as a psychologist I'm there to help people… my client comes there for an hour for me to be fully present. Anything short of that is me not living up to what I know myself to… I didn't do my work to the best of my ability when being impatient with my client. It's like bringing emotions that are not about the session, that are about me. (Thabisile)*

When Brett, Susan and Thabisile were unable to meet their own self-imposed, seemingly unachievable criteria, they questioned their competence as a psychologist.

> *Am I a good enough psychologist if I get like that with my clients? Did that client have a positive session? It's self-doubt that I did a good enough - I ran a good enough process or whatever - for that client…if it's a first time client, are they going to want to come*

back? Was that a positive experience for them? That they're left with hope that this process is going to help them. (Thabisile)

Accordingly, participants' statements appeared to reflect a cognitive distortion in the form of overgeneralisation. When participants perceived themselves to have failed in one session, they appeared to attribute this failure to their career as a whole and deduce that they might not be competent therapists and therefore not good enough. Susan and Brett took their questions around competency even further, wondering if they should be psychologists at all, and this again points to the unrealistic self-imposed standards. Participants appeared to carry the inherent belief that if they are not perfect and infallible, they should not be practising. This demonstrates the extent to which the standards are held and shows what failure to adhere to these standards means to some psychologists.

I'll admit I think there were times where I actually thought to myself, 'Maybe I shouldn't be a psychologist at all, I'm not designed for this work', as in, I don't have the resilience. I think that - again it's obviously connected to my idea of what should cause burnout - but I just obviously felt like I'm not resilient enough…so I suppose by default not good enough then, that a psychologist is meant to be resilient and not experience burnout for no apparent reason… but then I would have some really amazing sessions, and then that would reaffirm me so it was kind of a bit of a rollercoaster really. (Susan)

Why did I do this? Regretting your decision, feeling like you don't want to be here…(Brett)

Brett's use of the word 'your' instead of 'my' and 'I' indicates a possible attempt to disconnect from the unpleasant emotions associated with the memory he was recalling.

Maria, Thabisile and Brett described a shift in their empathetic presence in session. They struggled to be in the moment with their clients and noticed that they had gravitated towards more directive or solution-focused methods. They appeared to lack the capacity to allow the client to move at their own pace and had an inclination to 'do the work' for the client and, in so doing, rush the process. In addition to this, half the participants related a distressing reduction in compassion (compassion fatigue) towards their clients. When these participants realised this, they judged themselves harshly and engaged in negative 'how could I?' talk. In a way, lack of compassion for clients had extended to themselves too.

For me, I think the major tell-tale sign is when I honestly, 'Should I care?' that lack of compassion. That for me is the biggest. (Thabisile)

Although most participants appeared open and authentic when telling their story, there was a distinct uneasiness when describing loss of compassion and deficits in the client-therapist relationship. Some participants paused frequently, as if measuring their words. Others tried to use humour to diffuse the seriousness of the disclosure. This appears linked to role expectations in the profession. Psychologists are expected to be 'healers', and it is difficult to admit, as 'a healer', that one also needs to be healed or one is failing to provide healing. This perceived failure to perform the essence of their role appeared to bring about a profound sense of failure in the participants.

All participants' responses reflected a need to do more or give more to their clients and their profession as a whole. Their expectations on themselves were linked to performance and this showed in the way they expressed their experience of burnout and the words they used.

I actually felt that I wasn't quite in top form. (Susan)

…when you are emotionally, psychologically and physically tired and you actually are not able to perform at your optimum… (Zinhle)

Zinhle also spoke about the feeling of needing to do more, however, her need appeared to be embedded within the South African context. She experienced feelings of helplessness as a result of practising in such an unequal society. Zinhle reported that her clients were suffering from factors out of her control, and that her role as an emotional and psychological helper were less valid or less important. She appeared to feel that she was not able to assist her clients with the real issues they were experiencing and this led her to question her role as a psychologist in South Africa.

…looking at our history, we live in a very unequal society and sometimes I feel that psychology… my experience would be sometimes I feel it that we not… I would question our role whether it needs to change because of the unequal society that we live in… mental health is not really the… you know if you see a patient who is struggling emotionally or psychologically but that is actually not their primary problem… there are bigger issues like poverty… sometimes there's a lot of feeling like helplessness...

feeling that you're actually doing enough... wondering if you are actually making a difference… (Zinhle)

For the majority of the participants, there was an underlying sense of needing to be superhuman and not show their weaknesses despite their internal struggles. Half of the participants felt strongly about not letting their clients down that they continued to work and see clients even when severely burnt out. There was a strong sense of duty and obligation amongst the participants and a lack of compassion towards themselves. Susan noted experiencing burnout and yet she failed to prioritise self-care. Susan used descriptive imagery that evoked the image of one who has fallen down, and is dragging herself onward, unable to muster the energy to get up. A paucity of self-compassion was evident in her narrative.

…I'll literally have to drag myself out of bed in the morning because, I have to do this, but it's not something I feel like doing. (Susan)

…I'm quite hard on myself. I don't like to admit that I'm struggling, I don't think I should be struggling, maybe there's that 'Should' issue that comes into the equation where I'm saying to myself, 'This is nonsense, I shouldn't be struggling. I'm fine, I'm not taking on ridiculous amounts of clients, I should be fine.' Then it becomes almost like a [pause] yeah, where I'm not empathising at all with myself, and just saying, 'Come' - like I get out the stick basically and I say, 'Come on just keep going, you'll be okay, you're going to come right'. (Susan)

When experiencing burnout, several of the participants felt angry with themselves that they were not able to perform at their optimum, indicating the extent of their self-blame. Participants seemed to have certain expectations of themselves and when their expectations do not meet reality, there is a fallout. There appears to be unwritten rules regarding what a psychologist should be and what they should be able to handle. A lack of self-compassion was evident in several participants. This anger extended not only to their sub-par performance in therapy but to the way they managed their burnout. Susan engaged in negative self-talk when she was unable to pull herself out of burnout. She felt like her body and her mind were rebelling and refusing to do what she wanted or needed to do. This is also connected to a later theme 'Self-protection: a lofty goal' as it points to some of the barriers to managing burnout effectively.

'What's wrong with me, why can't I actually just regroup, what's going on with me, why can't I actually sort myself out during the time of rest?' I don't know it's difficult to say, I do feel like my [pause] I do feel like my body and my emotional state are actually quite non-conformist. [Both laugh] (Susan)

Susan's laugh after she stated that her body and emotions were not conforming again suggests the use of humour in order to diffuse distress.

Some participants perceived psychologists as being dishonest and felt they projected a façade of coping. They felt psychologists were unable to admit they are burnt out for fear of judgement and stigma from both the public and other professionals. Psychologists receive implicit messages that they need to 'have it all together'. Because of this, many participants felt they could not be honest about experiencing burnout and even struggled to admit it in the safe space of the interview. Due to this, many participants felt alone in their experience. This lack of universality led them to question their competence as they felt it was only them experiencing burnout and, therefore, there must be something inherently wrong with them if others in the profession were able to cope.

…I think there's always a little bit of a fear then of judgement [pause] because I mean that's certainly something in the psychological profession, is that people don't willingly show their vulnerability. (Susan)

…that's like an expectation, don't ask me where it came from, that as psychologists we don't - wouldn't have mental health issues, like we're not human [laughs]. (Thabisile)

Lerato also felt a sense of shame and a need to hide her burnout from colleagues. However, Lerato's case this wasn't merely self-stigma, there were real consequences to being burnout out and she was not supported at an organisational level.

…you cannot allow it to happen or you cannot allow it to be seen. You have to be burnt out in your own way and quickly find a way of getting [over it]… cause that's what we trying to do with them as well, when a person is burnt out our job mainly there is to help them get back to work as quick as possible so you can't also now be the one who is not in action for two or three days because you're advocating [for them to get back to work]... and that's what as well differs in terms of our work here, in a normal

environment where you saying oh okay you can take a few days off.. but there you can't... (Lerato)

Lerato felt that because she wasn't allowed to show or acknowledge her burnout, she had not fully resolved that experience. She compared the feeling to post-traumatic stress disorder and her distress was clear in the way she used the interview to debrief.

…unless I'm asked about a specific incident, then I'll be like 'oh okay then I can speak about it' but the emotions and how it made me feel at that time I think I did supress a lot of ... maybe it's also part of me now because it's not yet resolved... (Lerato)

…it may have a bit of a stigma because there are other people that don't understand what it means and you are expected to have this emotional [resilience]… we were having this talk with my other colleague who was there cause you are basically put on a very high pedestal that... things should not affect you… you know he even said that he's seen as a demigod because a whole lot of things, you are put in that position. So if you are seen to be cracking or are having any problems then people lose trust in you and you can't afford to have people losing trust in your when you are in that space. (Lerato)

Lerato perceived the lack of authenticity in burnt out psychologists as being intentional, perhaps missing the significant effect stigma has on help-seeking behaviours. This may indicate she blames herself for not being open and honest and struggles to externalise the blame. Lerato appeared to make internal attributions for her burnout and described seeing a lifeline and intentionally not reaching for it.

…on the other side, it's that sometimes we actually do this to ourselves where we do not let it out or we do not have... either intentionally by feeling like okay no if I talk to my friends or talk to someone else I may feel like you know I'm not really doing my job or I'm failing or sometimes not knowing who to talk to about certain things. (Lerato)

While some participants felt they couldn't be honest about their burnout, Thabisile and Maria felt that burnout was less stigmatised in psychology than in other professions. Their responses reflected the perception that there is a level of mutual understanding and compassion and that many people are aware how easy it is to burnout in the profession. Interestingly, while Thabisile and Maria both claimed there was not a stigma associated with burnout in the profession, they

were two of the participants that found it hardest to admit they were ever burnt out. This reflects a possible dissonance between what they want to believe and the reality.

I think actually there is a level of understanding that the work that we do is emotionally, can be emotionally taxing and heavy… I get a few clients after a session like, 'How do you do this, I would never be able to do this. How do you - how are you able to contain and take in different people's journeys that may be difficult in different ways, and still be okay?' (Thabisile)

I personally do not stigmatise psychologists that have burnout, I completely understand how it is so possible for that to happen…I certainly think as a profession, we as a profession understand how it works, we understand the mechanisms, so I don't think there's a stigma. I think there's a strong awareness of burnout, and I think there's a support system, a kind of unspoken support system when somebody is heading in that direction…I think it's just the profession is aware that in the work that we do burnout is really possible...I don't experience the awareness of the stigma. I think stigma happens in other professions, very much so, but I don't think in ours. (Maria)

Thabisile and Zinhle initially stated burnout is not stigmatised in the psychology profession, however, they also spoke of being put on a pedestal and being expected to be untouched by human struggles. This indicates there is a degree of stigma attached to impaired functioning, although not always overt in nature. This is likely connected to expectations arising from unrealistic standards in the profession and therefore might not be recognised as stigma initially.

…that's like an expectation, don't ask me where it came from, that as psychologists we don't - wouldn't have mental health issues, like we're not human [laughs]. (Thabisile)

…based on my own experience and my own views it's because psychologists… I don't know if it's the pressure that we put on ourselves... you know the view that you should be... you know you can't... what's the word... you can't be emotional you should be able to hold it… if you can't deal with your own issues how then are you expected to deal with other people's issues? So I think it's that thing of, you know, psychologists feeling as you know ourselves as superhuman or as not human … I think it's just our own pressure that is put on ourselves to be great and not have mental health struggles yourself because you're expected to be well-adjusted and emotionally…self-aware and have self-awareness and just be able to cope with things. (Zinhle)

Zinhle pointed out the irony of putting on a superhuman façade, stating that people relate to you better if you show your weakness and humanity. This again indicates a disconnect from belief and reality.

Some participants initially struggled to admit that they stigmatised other professionals experiencing burnout, however, their responses revealed that they unintentionally do so. Within the profession of psychology, psychologists seem to look at other professionals who are not coping and judge their ability to do their work.

> *…my perception of them as a professional changed… In a way, you could consider that stigma because I haven't had any personal interaction with them to determine whether or not they're good at their job, but from what I was hearing from colleagues, it altered my perception of them to this day. (Brett)*

> *Interviewer: So do you think that's why the stigma exists, if there is a stigma at all, because of that almost age-old Freudian, infallible blank slate, all-knowing therapist, and then when you find out they're human and actually a little bit broken...*

> *Susan: The disappointment.*

6.6 Multi-faceted impact of burnout

All of the participants described effects of burnout that were broad and systemic, often affecting them in several areas: occupationally, psychologically, physiologically, and socially. No participant experienced symptoms in one single area. While there were some similarities across several of the participants, each experience appeared quite unique.

The majority of participants experienced psychological symptoms. They experienced emotional exhaustion, tearfulness, irritability and an increase in anxiety. In addition, they experienced cognitive distortions and negative self-talk. Susan, Zinhle and Lerato experienced a sense of hopelessness and helplessness at times.

> *…it's probably the first time and only time that anybody…has ever seen me so upset, and I just [pause] screamed, and shouted, and told them to leave me alone, slammed a few things down, and then the next day I was so tearful. (Maria)*

> *…I may have been quite snappy than usual [laughs]. (Zinhle)*

Zinhle's chuckle after admitting to being snappy seems to be a response to feeling uncomfortable admitting to being irritable, again pointing to a level of self-judgement described above.

Susan and Brett described feelings of anxiety and apprehension leading up to work or to a session with a difficult client. They both felt dread and wondered about their ability to cope. Brett experienced insomnia and butterflies in his stomach on a Sunday night. Brett noticed that these feelings of anxiety and irritability were a departure from his usual state of mind and it led to some obsessive behaviours that he did not usually perform.

> *I was very short, I got frustrated very easily, I was quite irritable, general fidgetiness, if I want to explain it like that. Double-checking I hadn't forgotten stuff, feeling like I'd forgotten things, you know just not the usual relaxed, calm person that I usually am. (Brett)*

Susan seemed to feel desperation, hopelessness and a need to escape, demonstrating the overwhelming nature of burnout. These feelings of escape did not appear to be short term and Susan therefore questioned her ability to continue in the profession for an extended period.

> *…I must admit that the thoughts that sometimes come into my mind then is that I can't do this forever, I can't carry on seeing these clients on a day to day - day, after day, after day forever, I'm going to have to find something else to give me a break. (Susan)*

Susan's repetition of the word 'day' captures the monotonous and hopeless nature of her experience. In addition, her use of the clause 'I must admit' indicates her shame around not coping and questioning her resilience as a practitioner.

All of the participants' self-esteem seemed to be negatively influenced by burnout, some more so than others. They tended to make internal attributions about their struggle at work. This is also linked to the cognitive distortions described above under psychological impact of burnout. Participants who struggled with burnout negatively influencing their work often made generalisations, linking their perceived failures in-session to a failure at being a psychologist or even at a deeper level, a failure in life in general.

> *So in some ways, I'm not good enough. (Susan)*

…there were definitely times when I would doubt myself based on what was happening and how some people may respond to certain things and [pause] like maybe there [were] things that I could have done better or could have done more and things like that. (Lerato)

…it definitely made me question, 'What kind of a person am I becoming?' and that it's not the kind of person I usually am. Yeah, I think it definitely affected the way that I saw myself, my self-concept… (Brett)

Maria disclosed that while she may have moments where she questions her ability, they are short-lived. Later in the interview she attributed this to the fact that she felt this career had been a lifelong calling for her.

I do go through momentary bouts where I question, 'Do I know what I'm doing, am I good enough' but I promise you it's momentary. It's not... I don't stay there for long enough for it to have any impact on me. (Maria)

Maria's responses demonstrated a possible enmeshment with the career and this could lead to more negative internal attributions during burnout.

I decided to be a psychologist when I was 16 years old, and I knew, I knew, I knew, it's one of those very likeable moments in my life, so I'm not going to now go and question whether I'm the right person, or done the right thing. It was... I kind of feel like my purpose in life is being fulfilled... (Maria)

One of the most notable psychological effects of burnout seems to be the negative impact on one's self-concept. Some participants appeared to have a tendency to take interactions personally. The ability to avoid internalising failures at work as a failure of being, or a failure of character, is an important protective factor. Brett brought up the importance of having a wider sense of self-concept than simply being a person who helps others. If a person isn't able to help others, or is impaired in that ability, they are left wondering who they are and what their purpose is.

I'm a naturally relaxed and calm person, I don't tend to jump to conclusions or start misinterpreting things as personal attacks on my character… (Brett)

People get confused, you don't know what's yours and what's not, so taking it all on results in you burning out. (Brett)

Brett reflected on the need for one's identity to be rooted in something greater than one's career as a psychologist. He seemed to suggest that if one's identity was too closely linked with one's career it would cause more distressing emotions that would lead to burnout. Having a wider sense of being appears to be a protective factor in this sense. Lerato also felt that it was important to separate the personal from the professional. Doing so appeared to bolster her resilience. Her responses suggest the importance of insight in protecting one's self-concept. This is linked to a later theme 'Self-protection: a lofty goal' which suggests that insight and reflexivity in an important factor in being able to protect oneself from burnout.

…and I had to be reminded constantly this is why I'm here and I'm gonna provide the best service that I can whether I am liked or not liked it is not... and that got me in so much trouble as well... but I was able to withstand it and deal with it, knowing for certain that what I'm doing is right for the person that is my client or my patient at that time. (Lerato)

All the participants' responses suggested some degree of physiological impact. Chronic fatigue was most prominent. Other symptoms included hypervigilance, headaches, muscle tension, weight gain and skin breakouts.

I think for me where it mainly manifests is in headaches, and in neck and upper back pain…I suspect it was because I was tense. I'm sitting there, I'm feeling a little bit like I'm not in control of the situation and therefore I'm tense…and then also I definitely did get [pause] sort of just like minor health issues. More colds than I would normally get…just often feeling a bit off colour and not really knowing exactly what that is… a day or two where I would just be off colour, not feeling well, major headaches, whatever the case may be, and it certainly was a lot more when I was not in a good space. (Susan)

Lerato had to use substances (Coca-Cola) to cope with feeling exhausted most of the time and found she could not cope without it. This suggests a level of dependency and demonstrates that psychologists have to find a way to push on against all odds.

If I know that I'm going into a session that I know is gonna be difficult and... cause it was mostly group work after a trauma so you know you gonna be receiving a lot of

> *emotions and things like that so I... I would definitely drink coke like it was my… I think I became a little bit addicted to it, if that's the word, cause it would just give you energy and then after you finished with the session – totally exhausted – and I would want to just sleep. So I don't know how much of it was my [laughs] own thinking that coke is helping me but it sure did wonders for my physical body cause I was like the more I drink it I feel like I can stand with these people, I can listen and then I go and I crash after that. (Lerato)*

Every participant described some level of social withdrawal or a deficit in their usual level of social functioning when they were burnt out. This may be linked to compassion fatigue as social interactions take emotional energy and require socio-emotional reciprocity. Social withdrawal may also be connected to physical tiredness.

> *I have a choice to spend it on my own doing what a feel like doing, and not tending to other humans. I have enough humans in my office. (Thabisile)*

The use of the word 'humans' by Thabisile feels cold and unemotional, making her compassion fatigue and social disconnection quite evident. Thabisile noticed these changes in the therapy room and stated that she experienced a loss of empathy and impatience.

> *…a feeling of less capacity to function in the role that you function in, and as a psychologist not being able to be present fully, and not having your heart fully present with each person, and finding it difficult to [pause] be compassionate…so when I can't - when a person cannot be fully available emotionally for, when I say yes, fully available for a client emotionally, that for me is - would be burnout and not having capacity to take on more because there's just no space to take on more. (Thabisile)*

Susan, Brett and Zinhle felt that they remained therapeutically functional and did not experience in-session changes while burnt out and it was their administration and case management that were negatively affected.

> *I don't believe it affects my therapeutic work at all because, you know, when I'm with my clients I'm a hundred percent there… (Susan)*

While Susan, Brett and Zinhle initially stated that their work in-session was not affected at all, with further reflection they later admitted that they found themselves less empathetic and less

patient than usual. Participants more readily disclosed deficits in peripheral areas (such as administration), however, they were hesitant to acknowledge deficits in-session, particularly in their relationship with their clients. This is linked to the healer self-concept mentioned earlier in this chapter. The psychology profession is not about administration, thus proficiency in administration is not linked to self-concept and therefore not viewed with such importance. In-session work being affected may communicate a greater failure and this may be the reason it is harder to reflect on and acknowledge.

> *I don't remember there ever being a situation where I wasn't responsive to a client because I think I'm quite good at compartmentalising a little bit in that respect when I'm with my client, I'm with my client, and I'm all there. (Susan)*

Susan later contradicted herself and stated:

> *Thinking about that, I mean I probably would have tried less hard. I'm normally very active in my therapy, I'm not one of those therapists that just sits back and listens. I'm quite - I don't give advice as such, but I'm quite - I'm very interactive, and I ask a lot of questions, and I - you know so I'm very, very active in my sessions, and most of my clients find that very, very helpful. But I think you'd probably find that with the odd one I would literally just sit back and say, 'Ugh, just let them talk rubbish'. (Susan)*

6.7 Risky Business

All of the participants' responses suggested how the nature of the work predisposed them to burnout. Certain risk factors, inherent in the profession of psychology, such as high workload, emotionally demanding cases and trauma generally brought about feelings of burnout. Workload appeared to be one of the most significant risk factors. An excessive workload left participants feeling emotionally and physically exhausted, unprepared for sessions and increased their anxiety and negative self-talk.

> *…for me, burnout is the load - it's brought about more by the load that I'm carrying not the content of my cases… my burnout is not because of what clients bring to me, it's just me feeling overstretched. (Thabisile)*

> *…when it comes to working in the hospital it's just like, 'Go, go, go!'. You've got to figure out what to do, you've got to make a plan, and there was a lot happening… (Brett)*

…24 hours in the day is way too limiting. I used to say to people, 'I do not like sleeping because it's a waste of time'. (Maria)

…there wasn't a day where I'd say no it's Sunday or it's my time now I can't do this or it's a Monday, it's 8 o'clock… if somebody knocks and they have an emergency at that time I have to attend to it. (Lerato)

Although workload is often imposed upon a person due to expectations by superiors and organisations, in Zinhle's case it was a pressure to perform and her personality which led her to take on more than is healthy.

I'm someone who sometimes tends to take on more than I should. So sometimes I tend to take more than I should. It's nothing I can't handle... I can handle it but you know I put myself under pressure so I think I was taking on too much… (Zinhle)

Maria reflected on her experience in childhood, stating that she was raised to be useful and focus on doing, rather than being and this has carried through into adulthood and her career as a psychologist. Her childhood adaptions suggest a possible parentification. If she is tired and unable to perform at her optimum, she is then left feeling frustrated and unhappy. This process of socialisation indicates how some participants were raised to give of themselves to others, predisposing them to possible burnout.

I've got a photograph of myself when I was nine years old, on the back my Mum has written, 'This is our little [name] nothing is too much trouble for her'. (Maria)

I grew up with a lot of strong, strong social messages around, 'Nothing is too much trouble for me, I will do anything' and of course a lot of it was about pleasing and needing to please. (Maria)

All participants' responses indicated that the onset of burnout is usually insidious and participants often did not recognise it occurring until it was too late. Some could recognise something was 'off' but could not place it. Brett stated that he could tell something was off but didn't realise immediately. It appears that hindsight is important as it is easier to recognise burnout after it has occurred or the second time it is being experienced.

…it's not like there's a very distinct beginning, it's more just I'll start to notice that I'm tired, I'm not actually looking forward to my day, and that feeling gets worse and worse

as I become more burnt out to the point where sometimes I'll literally have to drag myself out of bed in the morning… (Susan)

…in hindsight I started realising that it was six months... even though at that time I didn't really think that it could be burnout I was just feeling a bit tired and I thought okay maybe because we were halfway through the year. I never thought it was something that could be abnormal… (Zinhle)

Those who had been burnt out before were more sensitive to the onset and could recognise it occurring earlier. Thabisile relayed that she had certain tell-tale signs that she now recognised as the beginnings of burnout.

…now I am very aware when I'm starting to be a little bit snappy and not really [okay] - and then I generally take care of that. In the beginning of my work in private practice, it would probably - by the time I realised it had been a long time and yeah it would be a long time that I have been burnt out but not recognising it as such. (Thabisile)

Brett's responses indicated that he was not initially able to recognise burnout occurring in himself, however, his partner noticed something was wrong and, through that external perspective he was able to achieve greater insight.

[My partner said] 'You seem a little bit off. Why are you so worried about work, you weren't like that before so has something changed?' Yeah, so just being my sounding board. (Brett)

The majority of participants' responses suggested a difficulty in holding and containing horror and trauma without being able to express it to the patient or to others. This process is inherent in the work of psychologists and is emotionally draining. In addition to this, an intense presence is expected during sessions and participants expressed finding it difficult to maintain the level required at all times.

…being the container, so knowing that I have to actually be strong for them, and to not be horrified by what they've been through. I think containment on the part of the therapist is also quite tiring. (Susan)

…in terms of work there were some things like the cases that I would see or I would hear… we had instances where one of our guys committed suicide so we had to deal

with such things… it was quite traumatic to see and to take people through that whole thing when they are traumatised when it was one of the people that I also was responsible for, so to say, and that happened and I heard it, I saw so that was a bit traumatic but it grew me as well…it is an excruciating experience but you really learn a lot about yourself… (Lerato)

Participants conveyed a sense of significant responsibility for their clients' lives. Some participants admitted to taking on too much responsibility for their clients and this led them to feelings of helplessness and hopelessness at times. This again suggests a level of enmeshment of personal and professional identity.

…what I actually realised…was that I was taking too much responsibility for them. (Susan)

…you are responsible for a lot of people at the same time… (Lerato)

Under the earlier theme of 'Idealised expectations of Self' Thabisile spoke of needing to help people and do more and feeling incapacitated by the South African socioeconomic context. This issue is also linked to the current theme of 'Psychologists are predisposed to burnout' as it highlights the difficulties inherent in the psychological profession in South Africa and how these can contribute to burnout.

Lerato appeared to feel that she had been forced to take responsibility for people's lives and was then blamed when she was perceived to have failed. For example, in the case of the suicide of a client, her organisation blamed her, stating that she should have done more to prevent this. The patient in question had never expressed suicidality to Thabisile and yet people questioned the usefulness of her role because of the incident. Lerato also felt the weight of loss through the other clients grieving and felt that she had lost their trust. This incident and how it was managed led Lerato to question herself and whether she could have done more, despite knowing deep down that she had done her job to the best of her ability.

…now there is a suicide case that is on my hands now so are people gonna trust what I'm gonna be saying to them or are they gonna open up to me now…(Lerato)

It was a bit challenging to go forward with them and people were angry and they did vent out to me in terms of their frustrations… How can you let this happen as a

psychologist? Why do we have a psychologist here if we gonna have someone killing themselves? You not good at your job you not… you didn't do your job…. (Lerato)

I was in quite a predicament at that time that I had to just accept that they are angry and they are angry that now I have failed at my services. At some point I felt like maybe I could have done more to help this young man not to kill himself but already also knowing that I couldn't have done anything. If he didn't come to me for assistance then there was nothing that I could have done. I couldn't have known. (Lerato)

All participants responses suggested that certain types of work pose a greater risk for burnout. One factor that presented almost across the sample, was the struggle to deal with clients who had existential or ongoing issues while the psychologists were experiencing burnt out. The participants seemed to find the lack of progression of the client particularly draining. These kinds of clients appeared to require the therapist to muster more physical and emotional energy in the session. When the participants were already running at a deficit, they are unable to conjure the level of energy required.

…there are existential issues that are like, 'Yeah sure, that's life'…'Are we going to keep sitting on this thing?' You know like where, when it's a trauma, you know it's [pause] how do I? You know when someone has gone through an experience, it's traumatic and they're struggling [pause] it doesn't tap into that. There's immediately a need to dig deeper even when I'm aware that I'm burnt out, but when it's everyday problems, I term them existential angst, that are not really - well every problem is serious to the person who's experiencing it, but at that time it's like, 'We can get on with this now'. (Thabisile)

…the worst clients for me are the ones that sit and never shift out of their stuff, never, ah they drive me crazy. So I just lose... I suppose that's where it does affect because I lose interest, and lose enthusiasm, and then I stop listening and then want to fix. Just give a bunch of solutions and give them a list of what to do, and tell them to go away and leave me alone. (Maria)

A risk factor for Susan was engaging in a lot of couple work. She appeared to take on a lot of responsibility for her clients in 'fixing' their relationship and did not acknowledge the responsibility of the clients for their own relationship.

I realised was that the more work I've been doing with couples, the more I've felt quite burnt out…couples work is very, very demanding. (Susan)

Susan, Brett and Maria noted than trauma work is possibly more prevalent in South Africa than in other countries and may pose a greater risk to burnout due to the threat of vicarious trauma. They expressed the difficulty of diving deep into their clients' stories while empathising and containing their displaced anxiety and anger. They found themselves having an increased sense of awareness to crime and violence in general. Susan and Brett both found themselves becoming hypervigilant after working with victims of violent crime, however they stated that this did not last long. Both Maria and Susan pointed out that South Africans have a high base-line level of anxiety due to the amount of interpersonal violence in the country. Maria described it as subliminal, hinting at the unconscious nature of the trauma that is carried.

…we live in a very, very, very highly stressed, traumatised environment. I think that probably as South Africans... there is a lack of safety... and it's maybe subliminal that we don't realise… (Maria)

Maria, when asked how it affects her work, acknowledged that although it difficult working with so much trauma, she felt that as South Africans people get accustomed to trauma in a sense and build an internal resilience as a result.

In addition to the nature of work, one's personality may predispose one to burnout. Most participants appeared to have some anxiety and neuroticism and this played out in their experience of burnout. Some participants were perfectionistic, highly driven and showed a need for control. In a profession that has very little predictability and control, persons with these personality traits are more likely to experience burnout. While they appeared cognisant of their personalities, they also appeared to lack insight into how this affects their experience of burnout.

I do think also personality-wise because I'm quite anxious, I like control. (Susan)

…it's the unanticipated because I am a great planner, and when it's... everything's so tight, that this thing comes along and, 'Where and how am I going to fit it in?' that creates anxiety for me. (Maria)

Considering Susan's perfectionism and need for control, it makes sense why couple work is so draining for her. Not only does she have two independent people to manage, there are a lot of dynamics between the couple outside of the therapy room that she cannot control.

Both Brett and Lerato appeared to handle uncertainty better than the other participants and described themselves as having typically laid-back natures. While most participants described personalities that may predispose them to burnout, Brett and Lerato appeared to have an internal resilience that, while unable to protect them completely from burnout, greatly mitigated their experience. They also appeared to experience a form of post-traumatic growth and were able to positively reflect on their experience.

> *…my general outlook on life, and my fairly relaxed character really did help to not let things get out of control. (Brett)*

> *…in terms of my personality but I think it helped me to quickly adjust to the situation. Cause as I said I'm a person who is up for a lot of adventure… (Lerato)*

The majority of participants experienced several external stressors, and this caused a need for their own containment. Due to the nature of their work, they were unable to process and contain themselves whilst simultaneously needing to contain their clients. It appears this led to them either 'shelving' their own stressors or being unable to be fully present and emotionally available in their sessions with clients. In addition to dealing with overt stressors, most participants held multiple roles (mother, father, daughter, wife etc.) and found that this contributed to them feeling emotionally stretched.

> *…when I am going through something personally and not processing it because I'm busy, but I'm not actively processing and working through it, I may have less emotional availability, and not even aware sometimes that I am not, but probably because I'm busy with my own stuff, and I am not as emotionally contained and connected to my own emotions as I need to be. (Thabisile)*

> *…my Gran was really ill, and she had gone to hospital, so then there was a lot of stress around that. I think if I was to say that anything had really influenced my experience of burnout…it was personal life circumstances… (Brett)*

…I still had to go to work, and be empathic with other people, meanwhile you're going through your own stuff. (Brett)

Maria has experienced multiple stressors in her family. Although she attributed her struggles in dealing with family stressors to having too many tasks to do, it is possible that her difficulty was linked to compassion fatigue and thus was struggling to find empathy and the emotional capacity required to deal with her family, in addition to her clients.

…in fact, if it was just therapy, and I was only doing therapy, I feel that I'm far more [pause] contained and less prone to the feelings of being exhausted…if it's just therapy I think I cope pretty well, but it's when all the other pieces come in, and the demands that require me to take responsibility, and do stuff that sometimes I don't think is my responsibility but I take on anyway… (Maria)

…my sister died of cancer, my other sister was hit by a taxi and landed up in hospital for six months and is pretty damaged by that, my mum's got dementia, my dad was frail, I think the other thing that does cause a lot of stress in my life is frailty and illness that ends up putting pressure on me to step into a caring role, not direct caring, not like I'm not the nurse aide, but I've now had to have power of attorney for both my parents, and for my two sisters, and that I think does... that's a big, big factor that creates a lot of stress in my life is that I just don't... I don't do well with sick people. (Maria)

6.8 Self-protection: a lofty goal

All of the participants responses suggested the need to act quickly against burnout and being pre-emptive with regard to self-care. Participants who had experienced burnout before were more sensitive to its precipitation and put preventive measures in place as soon as they noticed the warning signs. Thabisile and Brett were aware of their limits and what pace of work they preferred and structured their work schedule accordingly.

…now I don't even wait for it, I don't even wait for it. (Thabisile)

I schedule. I schedule myself out, I zone out. Every month I need at least four days or three days of not thinking, doing any work. That helps me to come back and just a chance of timeout. (Thabisile)

I focused on them a lot more proactively after that. It wasn't that I wasn't doing them [burnout mitigation efforts] before but maybe I wasn't putting much focus on them. (Brett)

All participants' responses indicated that self-care needs to be intentional and prioritised. The importance of a balance between work and leisure was often noted. Thabisile emphasised the importance of scheduling time off, highlighting the intentionality of her self-care. Time off, time away, time with friends, time alone, doing fun activities, reading, managing boundaries and playing sport were mentioned as management strategies for preventing or recovering from burnout. Susan noticed that she did not prioritise self-care and it was during times when she wasn't actively managing her stress that she noticed herself becoming burnt out.

I think taking time off and relaxing is obviously a huge part of self-care. So for me, I think that a lack of self-care normally is those - because there've been a few times where I've experienced a degree of burnout, last year being the worst, but I think it's when I actually don't make sure that I'm doing fun things, that life becomes generally stressful. (Susan)

Despite an acknowledgement of the importance of self-care across all participants, self-care is, more often than not, neglected and not prioritised. This is likely linked to the pressure of needing to do more and be the ideal therapist, leading to psychologists not taking enough time for themselves.

…I find whenever there's a lot to do I always... you know… I don't prioritise myself and it's a work in progress for me. (Zinhle)

Susan acknowledged that she failed to manage her burnout and continued working anyway. Susan felt particularly hopeless and despondent as she had taken extended time off and still felt burnt out. This led her to resort to ignoring her symptoms and pushing through.

I think my way of dealing with that is to just literally push through, to just keep on plodding on, day after day, after day, just keep on - and hoping like hell that it's just going to go away [both laugh] Bit silly isn't it? (Susan)

Evident across all participants' responses was the protective value of insight, self-awareness and active reflection. This insight was important, not only for recognising signs of burnout, but

for coping better with the demands of therapeutic work. Insight, self-awareness and active reflection were also important for managing counter transference, processing personal issues and triggers and differentiating between the 'client's stuff' and the 'therapist's stuff'. In addition to this, an internal locus of self-control was identified to be a protective factor as participants experienced less helplessness and were more active in their self-protection.

> *Sometimes we carry a backpack full of things and those things aren't always our own, you start to carry everyone else's backpacks or things that are meant to be in theirs, but now they're in yours, and so you start to feel that weight and pressure. Whereas for me, I feel like I'm quite good at distinguishing what's mine and what's not mine, and I'm - I have no shame to say, 'Sorry that's not about me'… (Brett)*

> *I think I am quite self-aware in terms of what I need...my transference and countertransference issues … (Maria)*

> *…when I get home and I want to sleep and I'm aware that I just can't sleep, then there's stuff that I need to reflect on and get - and go through. … It's like sorting it out neatly for the day, and then I can come back into my own space, and then I can do whatever I need to do… it closes that door and then I will deal with that the following morning. (Thabisile)*

Brett found that his reflective function was impaired when he was burnt out. He therefore found it useful to have people around him to mirror back to him what was happening.

> *I would say make sure you have people around you that know who you are as a person, so that when you're not recognising the signs of burnout in yourself because it's always so much harder to recognise something like that in yourself, have people around you that can recognise it, and they are close enough to you that they can say, 'I've noticed this, what's up?' and then being willing to talk about it without being defensive and stuff. Being willing to check yourself I think is super important. (Brett)*

Most of the participants needed to draw on social support systems when burnt out, whether it is family and friends, collegial support or personal therapy. Colleagues were often able to provide containment for participants.

I can't imagine if I had been on my own, then that really would have changed things. I think I would have been burnt out a lot sooner. Definitely being able to share the load with people really helps lessen that effect of burnout… (Brett)

…almost on a daily basis I will have that [pause] opportunity with one of my colleagues...To say, 'Whoa hang on a moment, what does this say about you?' or, 'What is this, what is this telling you?' or, 'Why are you reacting in that way?' I mean we do that a lot with each other all the time. (Maria)

'That community, oh yeah, oh yeah. That's why just stay plugged in with [the community] because it is such a validating, supportive circle of belonging.' (Maria)

In addition to colleagues, Maria and Zinhle sought the support of a supervisor or therapist of their own. Zinhle reflected on her burnout occurring at a time when she had not prioritised her own therapy and attributed that as a potential contributor to burnout.

…I have supervision so that gets covered in supervision over and over again. (Maria)

…in my position it's important for one to be in their own therapy it helps to work through your own emotional wellness and also to put things in perspective for yourself. So I've always been… since my own internship I have always been in my own therapy since I've been working and an outside psychologist... during that time because I didn't even have time so I wasn't in my own therapy… (Zinhle)

Apart from self-care, more than half of participants engaged in coping strategies and used healthy defences. Strategies such as compartmentalisation appear to be protective, if used appropriately. Susan reflected on her use of compartmentalisation and Maria described a similar strategy, although she referred to it under a different term.

I don't think I'm too bad about being able to put my clients into that box. (Susan)

…I do tend to switch off a little bit. I kind of dissociate I suppose, or switch off a little bit and try not to... I try not to engage too much with the thought processes… (Maria)

Brett reflected on his implementation of firm boundaries. This was extremely helpful for him and prevented him from literally and metaphorically carrying his work home with him.

I've always had that, I guess, awareness that self-care and personal time to do things I enjoy was important to me. I didn't take work home and that was a boundary I set for myself, and I stuck to it, and I still stick to it…I don't think about clients outside of work wherever possible. (Brett)

While self-isolation and social withdrawal is a symptom of burnout in some, it appears to be a useful coping strategy in others. Thabisile stated that time alone gives her the necessary 'me-time' she needs to recuperate.

…I have a choice to spend it on my own doing what a feel like doing, and not tending to other humans. I have enough humans in my office. (Thabisile)

A few participants felt that burnout could, and should, be avoided and that it is up to the individual to prevent it. Their responses indicated a perception that psychologists do not do enough to prevent burnout and that some even experience a sense of pride in being burnt out.

I honestly believe … if you are a psychologist specifically, you can avoid burnout, but of course, it would depend on what causes it, and when you have experienced it, it's not something that you want to keep as a recurring - it's not a badge of honour that 'I'm burnt out' no. [Both laugh] It's something that once you experience it and you know that 'I am prone to burnout if 1, 2, 3, 4, 5', then put measures in place. I'm big on self-care, I'm big on self-care. I really honestly schedule and do, and I prioritise it. It's not a nice-to-do; it's not a nice-to-have. I prioritise it and I believe that if a person can think of it as a reality in this kind of work, and understand how they get there, and then going forward you put measures in place, you actually can navigate this without having to be burnt out because it does affect people around you. (Thabisile)

…a lot of us as psychologists don't reach out for help when we need help… (Lerato)

7 DISCUSSION

7.1 Introduction

Burnout has been the source of a proliferation of research in the past few decades, however research has been predominantly quantitative and has neglected the lived experience of the phenomenon. Moreover, there has been a paucity of research on the experience of burnout among psychologists in South Africa. Thus, this study seeks to explore the experiences, understanding, perceptions or views of burnout within an IPA framework in order to look more deeply at the phenomenon and address the gaps identified in the literature review. The present study is the first known study to explore the experience of burnout among psychologists in South Africa within an IPA framework. This study seeks to explore how psychologists describe their experience, what the perceived risk factors and consequences are, their understanding of their help-seeking behaviours and how their particular context influences their experience. While there were some shared experiences between the participants in this study, their experiences were also unique and nuanced. Accordingly, the double hermeneutic stance embedded within IPA was particularly apposite for the present study as it fostered a distanced perspective from participants' lived experiences. Furthermore, the findings demonstrated a tendency amongst participants to lose their reflexive capacity whilst experiencing burnout. Accordingly, the researcher's perspective fostered another layer of understanding.

Five superordinate themes were identified in the data. The themes addressed the research questions and served to deepen the current understanding of burnout. A summary of key findings is presented below. This will be followed by a discussion of the findings in relation to extant literature.

7.2 Summary of key findings

The findings suggested that the participants experience an internal and external pressure to be 'superhuman' and perform at all times to a certain, unrealistic, standard. It is possible that participants experienced these feelings prior to registration as a psychologist and these feelings may have been exacerbated by the nature of the job, as Archer (2020) found that trainee psychologists had feelings of incompetence and insecurity and sought validation. The participants experienced feelings of guilt and self-blame when they did not conform to high standards of practice. It appeared that most of the sample took on a large amount of responsibility for their client's welfare.

The author observed a continual disavowal of burnout on the part of participants, and the use and intellectualisation as a coping mechanism to deal with the cognitive dissonance of expecting perfection and not performing to that standard. It appeared particularly difficult to admit a loss of compassion towards clients and clients. Many of the participants' identities seemed to be linked with their profession and they saw their profession as an important part of who they are. It is possible that this is one of the reasons they struggled so much with their perceived 'underperformance' when burnt out.

The findings suggested that the onset of burnout was insidious for the participants in the present study. The participants recognised something was 'not right', but active self-care activities were only prioritised subsequent to a decline or loss of function. Whilst many participants were aware of self-care and management strategies for burnout, they often appeared to choose to ignore their symptoms and did not implement management strategies. The participants in this study who did not implement any management strategies either berated themselves for feeling burnt out or simply ignored the burnout symptoms and continued working without making any changes to their lives. Those who did implement burnout management strategies found they were not always effective and certain strategies that would be effective such as extended time off were not feasible for various reasons. Moreover, it appeared that the participants were able to recognise burnout better the second time they experienced burnout and took action to manage it quicker.

The findings suggest that experience and perception of these South African participants did not appear to be particularly distinct from other countries. The amount of trauma work did, however, result in some participants feeling overwhelmed. However, these feelings were generally brief and did not impact them significantly. South African psychologists appear to be resilient to trauma work. The participants were born and raised in this setting, and crime and trauma has become part of daily life. The findings also suggest that trauma work was perceived as rewarding to participants, even when they were burnt out. This is possibly due to the short-term and measurable nature of the work.

These key findings were carefully divided into the following five superordinate themes: description of burnout reflects inner experience; idealised expectations of self; multi-faceted impact of burnout; risky business; and self-protection: a lofty goal. A discussion of the findings in relation to the literature will follow.

7.3 Contextualising key findings in the literature

7.3.1 Description of burnout reflects inner experience

When participants described burnout as a construct, they appeared to project their own experience and perceptions onto their descriptions. They were asked initially to discuss a time when they experienced burnout and then asked again towards the end of the interview to define burnout broadly. The participants' descriptions appeared to fall into two distinct groups. Some participants gave clinical, 'textbook' descriptions while others used emotive words and descriptive analogies. Some participants appeared to disconnect from their own personal experience when asked about their lived experience of burnout. This process of intellectualisation was used as a protective strategy or defensive mechanism in order to quell anxiety and feel in control (McWilliams, 2011). The findings of this study suggest this may be connected to an internalised stigma against burnout as most participants struggled to admit they had been burnt out and appeared to divorce themselves from the experience. When describing burnout, participants were observed to resort to intellectualised, clinical descriptions. Their descriptions of burnout aligned with academic definitions of the construct, listing symptoms and categories of impaired functioning.

The majority of the psychologists in the study seemed to have an unconscious internalised stigma towards burnout and their intellectualised descriptions may be a reflection of this. This internalised stigma is reflected in other research (Mathison, 2020), however there is generally a paucity of research in this area. In the present study, some elements of burnout appeared more difficult to acknowledge than others. The participants seemed to have the most difficulty acknowledging that their burnout may have led to a loss of compassion for their clients. Admitting they are burnt out and experiencing compassion fatigue is likely to be particularly difficult for a healer whose role is to feel and communicate compassion to their clients. Accordingly, there may be an unconscious desire to separate themselves from the experience. Many of the participants in this study expressed that they had not experienced any stigma against burnout among their fellow psychologists and perceived them to be understanding and empathetic on this issue. This contrasts with the research which noted that mental health professionals often struggle with judgement from colleagues (Gilroy et al., 2001; Jamison, 1998).

Emotional descriptions of burnout appeared to be more personal and connected to the participants' actual experiences. Their descriptions conveyed a sense of being overwhelmed and helpless. For example, Maria compared the feeling of being burnt out to being like a robot, capturing the loss of vitality and spontaneity that may be experienced. Lerato compared burnout to drowning and being unable to reach for the life raft, reflecting the overwhelming nature of burnout and the feelings of helplessness associated with it. Brett compared his experience to continually using a credit card until there are no longer any credit left, showing the cost of caring described by Figley (2002). These emotive descriptions appeared to capture the essence of the experience of burnout more aptly than listing symptoms as most quantitative studies do so. When an emotion or experience is perceived as being painful or threatening, the natural response is for the mind to separate from those feelings (Cilliers, 2003). It is likely that as the participants made their peace with their experience and address their internalised stigma that their descriptions became more integrated, authentic and less 'textbook'. Interpreting why psychologists intellectualise in this present study is useful in understanding the experience of burnout and perceptions of it more fully. The emotive descriptions and analogies also captured the experience of burnout more comprehensively than when burnout experiences were described in accordance with symptomatology and diagnostic criteria.

7.3.2 Risk and protective factors

Childhood history and burnout

Many psychologists are drawn to the profession due to their own past. Research indicates that many mental health professionals are drawn to the profession due to their own trauma, abuse and parentification (Begni, 2005; Racusin et al., 1981). While this may give them the ability to be more empathetic with clients, Barnett et al. (2007) noted that individuals who have had difficult childhoods are at higher risk for developing maladaptive coping mechanisms. This was reflected particularly in Maria's narrative in which she described being a caregiver to her mother, driving a focus on needing to be useful. Although not as explicitly stated, a few other participants mentioned the feeling of 'needing to do more' and give more to others, hinting at similar childhood dynamics. These participants felt particularly responsibility for therapeutic outcomes and appeared to put undue pressure on themselves to perform. Traditional models of burnout tend to ignore the influence of personal history on an individual's risk for burnout. The findings in this study demonstrate that personal history not only poses a risk for the development of burnout but for the progression and management of it too. Psychologists whose

personal identity is closely linked with their job as a psychologist may question ‘if I am not a healer who am I?’. Maria stated that she believed she was meant to be a psychologist all her life. This interlinking of profession and identity may predispose a psychologist to burnout due to the fact that failure in the therapeutic setting is then attributed to a failure in oneself. It is likely that because psychologists generally take on a responsible, caretaking role, they will not look favourably upon themselves when they struggle with their own mental health and need care.

Personality traits and burnout

Several of the participants in this study described themselves as anxious and perfectionistic. These personality traits can cause inflexibility in individuals and cause them to struggle to adapt to uncertainty and accommodate distress (Mahoney & Moes, 1997). This was evident in the present study where participants who appeared to have more relaxed and adaptable personalities seemed to struggle with burnout less and reflect on it more positively.

Emotional demands and Burnout

Empathetic engagement and connection with distressed individuals is a risk factor for vicarious trauma (Pearlman & Saakvitne, 1995b) and burnout. Repeated exposure to traumatic experiences can cause disturbances in cognitive schemas, changing the way therapists view themselves, others and the world. (Trippany et al., 2004). Changes in cognitive schemas can have harmful effects on a psychologist’s personal and occupational functioning (Trippany et al., 2004).

Organisational and structural factors

In addition to internal processes, external processes can also be contributing factors to burnout. Findings from the present study indicate that all the participants had difficulty in managing a heavy workload. Psychologists working in South Africa are at particular risk with regard to high caseloads due to a shortage of mental health professionals in the country (HPCSA, 2018). Extant literature indicated that workload and the work setting are among the most common factors that contribute to burnout (McCormack et al., 2018). Psychologists who had manageable caseloads experienced less work-related stress than those with a higher caseload (Hellman, Morrison & Abramowitz, 1987). As such, it behoves organisational bodies and governmental structures to address systemic factors so as to reduce rates of burnout amongst

healthcare workers. In addition to a heavy caseload, Zinhle was burdened by the socioeconomic struggles in her clients. Being unable to address these structural issues left her feeling helpless and disillusioned with her role as a psychologist. Stress, regarding issues that are beyond the scope of psychological practice, is likely to be extremely draining and demoralising for psychologists. This too was not reflected in extant burnout literature.

A combination of possible adverse childhood experiences, a need to perform, stigma, working with distressed individuals in limited-resource settings can set South African psychologists on the path to burnout. These issues are not adequately reflected in existing burnout literature. Accordingly, the present study demonstrated that blanket risk factors to burnout do not exist and thus, demonstrated the need for research to engage with individual lived experiences of burnout within a particular context.

7.3.3 Idealised expectations of self

This theme addresses research questions relating to both the perceived risk factors and impact of burnout. Idealised expectations not only predispose psychologists to burnout but are also a consequence of burnout according to the findings.

Most participants experienced compassion fatigue, emotional numbing and detachment from both their clients and the content clients brought to therapy. Research demonstrates that this is a common symptom of burnout in psychologists (Sui & Padmanabhanunni, 2016). However, the literature focuses on how this impacts the work and does not explore the implications of this for the psychologist as a person. The present study found that due to the idealised expectations in the profession, many psychologists struggle to admit they are experiencing compassion fatigue, which in turn influences their ability to be reflective and actively acknowledge and address burnout. According to Cilliers (2003), burnout occurs when there is a disconnect between one's intentions and the reality of the workplace. This is evident in the findings of this study. Four participants within the present study noted that they had certain expectations for both themselves and the therapy session and that being unable to meet these expectations due to the reality of the job brought about feelings of frustration and disappointment. These feelings in turn caused them to work harder and increased their symptoms of burnout. Moreover, if a therapist views themselves as selfless and compassionate, it may come as an unwelcome surprise to themselves when they act in a manner that lacks compassion. Two participants expressed shame and disappointment when their intention of

being emotionally present and empathetic did not carry through into reality. In this way, their perception of themselves and how they 'should' be were at odds with their new, less than ideal emotions and behaviour, leading to negative views of themselves. In a collectivist country such as South Africa, notions of 'ubuntu' and cultural importance placed on community may exacerbate psychologists' need to provide for others. This was reflected particularly in Zinhle's interview, in which she appeared to feel disillusioned that in her role as a psychologist she was not able to help more. In addition, Thabisile noted that often a lack of medical aid prohibited her from continuing much needed therapy with a client.

Psychologists experience high performance demands from themselves, within the client-therapist relationship and within society as a whole (Freudenberger, 1982; Skovholt, 2012). The findings suggest that many participants feel personally responsible for therapeutic outcomes and this resulted in them taking too much responsibility for the process, possibly predisposing or exacerbating their experience of burnout. Research shows that over-involvement with clients is directly linked to both emotional exhaustion and depersonalisation (Raquepaw & Miller, 1989; Huebner, 1994). In addition, Hammond et al. (2018) identified that a potential barrier to overcoming burnout is the belief that their clients' expectations and needs are more important than their own – this was observed in the way participants spoke about their work. It appeared that participants believed they must give everything of themselves to their clients and when they fail to do so, they judge themselves harshly and renew their efforts to do more and give more. Further compounding this difficulty was when a participant felt ineffectual or when they are unable to address core issues for the client. In a South Africa, a country still suffering from the pervasive effects of historical oppression and inequality, psychologists are likely to be dealing with an additional layer of stress in their daily practice. This may be particularly true for those working in a public health setting as they are met with high caseloads and work predominantly with a socioeconomically disadvantaged population. When the client's issues go so far beyond the scope of practice, the psychologist can be left feeling incapacitated and helpless. Zinhle's responses reflected these difficulties and appear to have contributed to her burnout. She stated that she felt particularly tired and weighed down when working with socio-economically disadvantaged clients. She questioned the relevance of psychology in a nation that was suffering from so many socioeconomic issues and, although she did not state explicitly, seemed to feel that psychological issues were less important or were knock on effects of systemic issues needing to be addressed first. Psychologists who witness distress and are unable to help meaningfully may be at risk of moral injury. Moral injury is a

new concept in burnout research that arose in response to critique that current models of burnout do not adequately capture the experience of burnout in healthcare professions (Ford, 2019). Dean et al. (2019) state that moral injury occurs when “we perpetuate, bear witness to, or fail to prevent an act that transgresses our deeply held moral beliefs” (p. 400).

Psychologists experience shame when they experience the symptoms of disconnection and loss of empathy. The participants seemed to hold the belief that ‘there is something wrong with me if I’m not a certain way’, perpetuating a cycle of shame. Shame interrupts psychologists’ capacity for connection and so, the psychologist focuses on their own internal processes rather than the clients’ (Hartling et al., 2000). Participants appeared to experience a particularly strong sense of shame around a lack of positive outcomes in therapy and felt guilt for their waning patience and empathy.

Many participants reported self-blame when they experienced a lack of compassion towards certain types of clients. Participants voiced their struggle to deal with clients who had existential, pervasive and draining issues while they were experiencing burnout. These kinds of clients required the therapist to muster more physical and emotional energy in the session than what they had available. There is some research which purports this finding as associated with to countertransference phenomena. Countertransference involves the emotional reaction a psychologist has towards a client and is rooted in the psychologist’s prior life experiences (Figley, 1995b). It is typically experienced as a state mind during which the emotions of others are experienced as their own (Miller, 1993; Neumann et al., 1997). Stamm (2010) identified negative countertransference as one of the outcomes of compassion fatigue, demonstrating that countertransference and burnout are related. As psychologists experience increasing levels of burnout the distorted cognitions they experience as a result become unconscious and result in countertransference reactions towards their clients (Saakvitne & Pearlman, 1996). What is interesting to note is that the participants in this study did not refer to countertransference at all, even when talking about their in-session reactions to certain clients. They instead attributed these reactions to their own failings indicating how strong the sense of self-blame is that is causes a loss of reflexivity.

In addition to self-blame, most participants experienced a sense of self-doubt and questioned their competency when they were burnt out. Literature shows there is a significant connection between professional self-doubt and self-affiliation on interpersonal distress (Nissen-Lie et al., 2017). Rather than engaging in unhelpful self-blame, psychologists should rather ask ‘what

does it say about the client that I am struggling to feel compassion or remain present?' Most of the participants appeared to be so focussed on their own performance in therapy that they did not place sufficient importance on the client's role in therapy. Literature indicated that the state of the patient before therapy (adequacy of personality functioning, intelligence, affect, social functioning) is the best predictor of therapeutic outcomes (Luborsky et al., 1971). In other words, the higher functioning the patient is prior to therapy, the more likely they are to make significant and lasting improvements. Therapists may have less influence over the outcomes than the clients themselves, yet the findings of this study suggest they place almost sole responsibility on themselves for therapeutic outcomes.

7.3.4 Multi-faceted impact of burnout

Extant literature purports that burnout is different to depression due to the diffuse nature of depression and its impact on multiple areas of functioning (Basson & Rothmann, 2001 cited in Cilliers, 2003). However, the present study demonstrated that burnout pervades many areas of personal functioning including self-concept and relationships. Moreover, burnout is consistently referred to as a "work-related state of mind" in nomenclature (Cilliers, 2003, p. 29). However, the present study found that psychologists experience burnout symptoms in multiple areas of their lives.

Personal impact

Of the common symptoms of burnout, the psychological impact appeared to have the greatest ramifications in the present study. The psychological impact included feelings of self-doubt, guilt, shame, loss of empathy and a wounded self-concept.

Several participants in the present study experienced self-doubt and worry they were not doing a providing a sufficiently high-quality service within the psychotherapeutic space - a finding that correlates with other burnout research in psychologists. For instance, in a study by Philip (2004) most psychologists in the sample reported a reduced sense of self competence. According to literature, burnout appears to negatively affect a person's self-esteem. Esteem relates to the perceived value of, or regard for, oneself and others (Pearlman, 1995). Therapists who are deficient in esteem due to the consequences of burnout may question their ability to help their clients. This was observed in three of the participants who had questioned whether to continue their career path as a psychologist. Despite the perception of self-doubt being a

negative consequence, Nissen-Lie et al. (2017) noted a level of self-doubt as a psychologist can actually have a positive impact on therapy. It was postulated that professional self-doubt involves a psychologist having a healthy level of self-criticism, sensitivity and reflexivity. As such, self-doubt was purported as beneficial to the therapeutic process. Research demonstrates that psychologists who have a healthy level of self-criticism and who adopt an 'attitude of uncertainty' are more likely to be effective in therapy (Baltes & Smith, 1990; Macdonald & Mellor-Clark,2014; Nissen-Lie et al., 2017).

Participants in this study appeared to experience changes in their self-concept due to burnout and this in turn negatively influenced their feelings of competence and general self-esteem. Archer (2020) also noted changes in self-concept due to burnout in her participants. She found that these changes had a knock-on effect on the individual's relationships with friends, family and intimate partners. In addition to influencing personal relationships, the therapists' self-concept can influence therapeutic outcomes. Psychology is viewed by many as a calling (Begni, 2005) and this was evidenced by the participants in the present study. Due to this, a psychologist's self-concept and profession appear to be intricately linked. The findings from the present study revealed that a few participants experienced changes in their self-concept due to burnout. For example, Susan questioned whether she was 'good enough' and wondered whether she lacked resilience because she struggled with burnout. Research shows that aspects involved in burnout, such as vicarious trauma, can bring about disruptions in existing cognitive schemas and cause changes in the therapist's self-concept (Pearlman & Saakvitne, 1995). Internal processes such as frame of reference, self-capacity, ego resources, psychological needs and memory can be impacted (Saakvitne & Pearlman, 1996). One's frame of reference incorporates one's identity, belief system and world view (Trippany, Kress & Wilcoxon, 2004) and is thus the basis from which one filters and understands all experiences. Any disruption in an established frame of references can cause potential difficulties for the therapist both personally and in their therapeutic relationships (Trippany, Kress & Wilcoxon, 2004). This may explain why, when participants in the present study experienced difficulties in one area (work), they then viewed their own inherent qualities and abilities negatively.

One of the findings of this study that is reflected in the literature is that reduction in empathy towards clients occurs frequently in burnt out psychologists (Raquepaw & Miller, 1989). According to Pearlman and Saakvitne (1995a), burnout may negatively affect a person's self-capacity. Self-capacities refer to "inner capabilities that allow the individual to maintain a

consistent, coherent sense of identity, connection, and positive self-esteem" (Pearlman & Saakvitne, 1995a, p.64). Among other things, self-capacity allows a person to tolerate difficult emotions. A weakened sense of self-capacity may therefore cause implications for therapists in terms of the ability to contain and hold their client's distress. This was observed in several participants in the present study who experienced reduced empathy or compassion fatigue. They no longer had the ability to hold and process their clients' difficult emotions. The findings also revealed a sense of uneasiness admitting to functional impairments, particularly in the client-therapist relationship. This reaction is linked to idealised expectations of the self as mentioned earlier. Deficits in administration and seemingly superficial areas are easier to metabolise and deal with than a healer admitting they are unable to heal.

Four participants noted that they experienced a more significant reduction in empathy when working with long term clients who failed to meet therapeutic goals. Luborsky et al., (1971) posit that clients who show improvement may evoke more empathy in the therapist. This was evident in the findings of this dissertation. Clients who made little improvement or who were seemingly 'stuck' elicited the most frustration and brought about compassion fatigue.

In addition to psychological consequences, physical manifestations of burnout were evident across all participants. Cilliers (2003) suggests that this indicates the severity of threat as the system needs to displace its pain on a physical level. All the participants in this study experience some degree of physiological impact. They experience chronic fatigue, hypervigilance, headaches, muscle tension, weight gain and skin breakouts. This is consistent with literature on burnout that demonstrates that physiological manifestations are common (Melamed et al., 2006; Sui & Padmanabhanunni, 2016). Shanafelt et al. (2005) found that practitioners' well-being is associated with increased practitioner empathy thus it is likely the physical and emotional state of the participants in this study have a reciprocal effect on each other.

Interpersonal impact

The majority of participants in the present experienced some kind of social withdrawal. While they did not express significant relational breakdowns due to burnout, it did cause some loss of connection. Alfrey (2014) also observed a loss of connection with others in his psychologist participants, supporting the assertion by this author that burnout depletes a psychologist's 'social battery' leaving them with little emotional energy for social interactions. Thabisile

highlighted this by expressing that she had enough humans in her office and therefore didn't need more after hours. Even the use of the word 'humans' sounds impersonal and may signal a relational disconnect. According to literature, burnout appears to negatively affect a person's ego resources and intimacy needs. Ego resources refer to the ability to meet one's own psychological needs and the capacity to relate with and connect to others (Pearlman & Saakvitne, 1995a). Intimacy needs encapsulate the need for intra and interpersonal connection (Pearlman & Saakvitne, 1995a). Disruptions in this area can result in feelings of emptiness, loneliness and, conversely, social withdrawal (Pearlman, 1995).

7.3.5 Management of burnout

Reflection and adaption

The findings of this study suggest that an awareness of one's state of being is an important protective factor. The participants in this study who were able to reflect on their process of burnout, and adapt to the changes it brought, were more likely to experience what appeared to be a 'post-burnout growth'. Brett and Lerato appeared to have the ability to separate their negative thoughts and emotions associated with burnout without making negative attributions to their identity, and that enabled them to reflect on their negative experience of burnout in a positive way and draw strength from that experience. What they described appeared to be similar to post-traumatic growth and appeared to bolster them against future episodes of burnout. According to Thelen and Smith (2006), when an individual experiences a crisis, they are pushed to the tipping point and become more open to change. This allows them to adapt and develop additional coping mechanisms. This is likely what occurred in Brett and Lerato's cases. Although their experience of burnout was very distressing, they experienced positive growth following burnout, leading to greater awareness of burnout, insight into oneself and reflexivity. It is thus imperative that training institutions and/or psychological research advocate for reflexivity as a means to maintain self-care. Burnout associations are primarily negative in extant literature and positive growth, post-burnout, is an aspect of the experience that has been neglected in existing research.

Social support

Research indicated that most therapists find their own therapy to be helpful (Pope & Tabachnick, 1994). Having a supportive atmosphere in which to freely express oneself through supervision and mentoring is essential for coping and can increase therapist empathy and

compassion (Lyon, 1993; Papadomarkaki & Lewis, 2008). Moreover, peer supervision provides therapists with necessary validation and support, allowing them to vent their feelings (Oliveri & Waterman, 1993). In addition to providing emotional relief, discussion of therapeutic successes in supervision helps to reaffirm a therapist's confidence in his or her clinical skills (Pearlman & Saakvitne, 1995b). Several participants in the present study expressed a need for containment and emotional support, yet few mentioned personal therapy as one of their management strategies. Despite the literature clearly supporting personal therapy and supervision as an effective management strategy, it appears to be under-utilised by the psychologists in this study. This is likely due to several barriers to help-seeking identified in the present study.

7.3.6 Barriers to help-seeking

Unconscious stigma

Several participants felt that psychologists are not willing to be vulnerable and admit to being burnt out for fear of judgement. This is in line with other research that found trainee psychologists took on a "great pretender persona" and feared showing their true feelings and thus being perceived as weak (Archer, 2020, p.115). Some participants in the present study viewed burnout stigma as 'something that happens in other professions', thus distancing themselves from the experience. The findings revealed that stigma is often self-imposed – participants judged themselves harshly and questioned their competence as psychologists. Research demonstrates that there is stigma regarding psychologists who have mental illness (Gilroy et al., 2001; 2002), thus it is likely that any 'impairment' in functioning would be viewed in a similar manner.

Loss of reflective function

The need for pre-emptive management of burnout was repeatedly identified by participants in the present study. Although participants were aware of the strategies to manage burnout, they often lacked the reflexivity to recognise burnout in themselves while the symptoms were occurring. What also emerged was that prior experiences of successfully-managed burnout were associated with participants having greater capacity to recognise and pre-empt burnout symptoms the second time. Brett and Thabisile who were sensitised to burnout by previous experiences of it, actively sought to avoid burnout symptoms by implementing self-care strategies. The participants in the present study who had the capacity for reflexivity were

considered to fare better than those participants who did not recognise or neglected their symptoms of burnout. Alfrey (2014) found that psychologists tended to hide their struggles and continued working harder however research has shown that proactive coping is inversely related to burnout and positively related to self-efficacy and professional engagement (Schwarzer & Taubert, 2002). By pre-empting stress, individuals can build and develop resources to respond to acute or chronic stressors (Schwarzer & Taubert, 2002).

Self-perpetuating nature of burnout

Cilliers (2003) noted that burnout can be self-perpetuating as a result of inadequate coping strategies. The findings in the present study showed that several of the participants continued to push themselves to work at the same level despite experiencing significant difficulties due to burnout. They appeared to be self-sacrificing and continued to place their clients' welfare ahead of their own. This in turn lead to a decline in the participants' functioning and, ironically, their care for their clients. The participants, however, viewed this self-sacrifice with pride and did not always appear to perceive the negative implications and the toll it had on themselves. This is consistent with Crim's (2013) research on counsellors in which the participants identified their self-sacrifice as passion for their work.

Some participants in the present study highlighted the self-perpetuating nature of burnout in their interviews by describing their failed attempts to manage burnout effectively. Susan initially implemented management strategies when she experienced burnout the first time, however, these strategies had no impact and she continued to experience burnout. This left Susan feeling hopeless, and she wondered if her symptoms of burnout would be chronic. This correlates with Alfrey's (2014) study in which one of the participants expressed a similar concern, wondering if the symptoms of burnout would ever cease. This suggests that this may be a common experience and indicates a need for more research in this regard. Furthermore, when Susan was unable to manage her burnout, she questioned whether she was suited for the profession and whether she lacked the resilience required to be a psychologist. Once she had established that her methods were ineffective, Susan responded by ignoring her symptoms and burying herself further into her work. The more severe her symptoms became, the harder she fought to ignore them. This is an element of burnout that is not featured in existing burnout research. It is important that this is explored further in other research as it sheds light onto the possible reasons for management strategies failing to meaningfully decrease the prevalence of burnout in psychologists.

As demonstrated above, various barriers to help-seeking were identified in the findings that have not been emphasised in existing burnout research including: (1) internalised stigma; (2) lack of reflexivity and insight; (3) denial; and (4) hopelessness. The findings of this study point to a destructive cycle of burnout originating due to participants' idealised expectations of self. The psychologists within the present sample questioned their competence and ability when they failed to meet their own idealised expectations. This in turn led them to take on a higher workload, and become solution focused in an attempt to quell the feeling of not being enough. The findings of the present study demonstrated that many psychologists held beliefs that they are 'superhuman' and thus, they entered into a cycle of shame and denial when their flaws emerged. Participants failed to acknowledge the true reason behind their impaired functioning. They either experienced frustration and self-criticism or participants denied burnout symptoms were happening at all. Internalised stigma and denial are barriers to help seeking which perpetuates the cycle further (Corrigan et al., 2015; Endriulaitienė et al., 2019; Schulze, 2007). Accordingly, the very mechanisms that cause burnout are considered the ones that prevent psychologists from managing it effectively. However, burnout literature does not adequately address the self-perpetuating nature of burnout. The findings of this study provide an idiographic account of the cycle and give an indication of why burnout may be so difficult to manage in psychologists in the South African context.

8 CONCLUSION

8.1 Importance and implications of findings

This study highlights the complexity of burnout and the varying management strategies thereof. The present study demonstrated that as the psychologists continued working throughout their burnout experience, there were impairments in their functioning both within and outside the psychotherapy room. Ethically, psychologists have a duty to ensure they are conforming to standards of best practice. As essential 'tools' within the therapeutic room, psychologists have a responsibility to ensure they are looking after themselves in a way that protects and cares for their clients. Failing to provide psychologists with the adequate support in dealing with burnout is akin to soldiers being sent into a war with no weapons – it is doing the profession and the practising individuals a disservice by disavowing the experience of burnout and impact thereof.

The findings of this study have implications for practising psychologists both in South Africa and broader contexts. It is evident that burnout is a complex phenomenon and the experience of it is not yet thoroughly understood. It appears that, not only are South African psychologists predisposed to burnout due to various contextual factors, but they lack the capacity to engage in adequate management strategies. For instance, a plethora of South African literature notes that psychological training does not adequately prepare psychologists to deal with burnout and does not emphasise help-seeking behaviours (Ally, 2014).

Increasing understanding of the reciprocal influences between psychologists and their clients highlights some practical implications for the training of new therapists, the continuing education of practitioners and the priority of self-care for therapists. Trainee psychologists should be made aware that their career is likely to result in personal changes during their lifetime. In continuing professional education and developmental, there should be a sensitivity to the demands of clinical work and the complexities of life as a psychologist. Given those demands and complexities, therapists should be encouraged during their training to prioritise their own self-care and to establish networks of support for one another (Radeke & Mahoney, 2000). Currently psychology training programmes appear to focus predominantly on the development of clinical skills. It is, however, equally important for trainees to be educated on the importance of personal psychotherapy, self-reflection and self-care (Barnett & Hillard, 2001). Research shows that individuals who are introduced to self-care and personal therapy early in their professional lives are more likely to seek such services throughout their careers

(Pope & Tabachnick, 1994). It is important that such self-care is comprehensive and addresses all the dimensions mentioned in this study.

The findings of the present study demonstrate that therapists do not always recognise and frequently disavow active burnout symptoms. Further awareness brought about by psychoeducation and training may serve as a preventative function and facilitate psychologists to recognise and address burnout when it is occurring. Once burnout occurs it appears difficult to successfully manage, therefore more care needs to be taken in preventing its occurrence. However, many psychologists interviewed in this study did not actively protect themselves and, worse so, continued to work through it. An awareness of the self-perpetuating cycle of psychologist burnout and the implications of allowing burnout to continue may help psychologists to carry out the necessary strategies to reduce the impact, thus minimising potential ethical and interpersonal difficulties. Due to the ethical implications associated with burnout symptoms, psychologists have a responsibility to minimise the potentiality of burnout symptoms and to manage symptoms adequately. It is, therefore, important that they first know what puts them at risk for burnout, how to recognise it and how they must respond.

Findings in this study indicate the presence of an internalised stigma that prevents the recognition and management of burnout. Moreover, both this present study and previous research indicate that psychologists' experiencing any kind of mental health difficulty feel judged by colleagues (Gilroy et al., 2001; 2002), indicating that psychologists experience stigma both internally and from external sources. Emphasis on self-care during the professional training process may aid in alleviating some of the negative stigma regarding burnout and mental illness among psychologists.

8.2 Limitations and Recommendations

A limitation identified in this study is the possibility that participants filtered their responses and were reluctant to be truly honest about their burnout. There appeared to be an underlying need to be seen as good and this is likely to bring about a level of guardedness, whether conscious or unconscious. Therefore, the findings may be influenced by how the participants wanted to be perceived and what they chose to share rather than the true experience. The researcher attempted to facilitate a safe, empathetic space in the interview in order to prevent this, however the possibility of 'tainted' findings must be noted.

In terms of methodology: using the ProQOL as inclusion criteria was also a possible limiting measure. Although it meant the research was able to identify the disparity between experiencing burnout symptomatically and insight into the occurrence, it resulted in the sampling of psychologists who had experienced burnout according to the criteria however were not aware of burnout symptoms which limited their ability to discuss their experience at a deeper level. In addition, the ProQOL's validity and reliability has been questioned (Hagan, 2019; Maila et al., 2020) and should perhaps have been replaced by a more robust measure of burnout.

The sample size of the present study was relatively small (N = 6). Although rich, detailed findings were elicited, due to the sample size the conclusions of this study are not generalisable. Although idiographic in nature, an effective IPA study should shed light on the phenomena in a broader context (Smith et al., 2009) however, it should not be regarded as a complete understanding of it. As such, further research on burnout among psychologists is encouraged.

An interesting finding that emerged in this study was the influence of childhood experiences and socialisation on the experience of burnout. It may be valuable for researchers to explore this factor in greater depth in future studies.

The researcher recommends that specific training on burnout be included in graduate training and post-graduate training. Recognising the signs of burnout and knowing how to actively protect oneself should be viewed as essential as any other counselling skill. Research by Hammond et al. (2018) identifies inadequate education regarding self-care as a barrier to overcoming burnout and thus supports this proposition by the researcher.

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10 APPENDICES

10.1 Appendix A – Consent Forms

Dear Participant,

I am a Masters student in Clinical Psychology at the University of KwaZulu-Natal (Howard College Campus). I am required to do a research dissertation as part of my training. My research investigates the experience of burnout among psychologists in South Africa.

You are invited to consider participating in a study that involves answering questions about your experience of burnout. Your participation is **voluntary** and you are entitled to withdraw from the study at any time without any consequences or prejudice. The study is expected to enrol approximately 6 psychologists. You will first be asked to complete a brief questionnaire with questions relating to compassion satisfaction and compassion fatigue in order to establish if you meet the inclusion criteria for the study. The questionnaire will take approximately 15 minutes to complete. If you fulfil the criteria, you will be included in the study. The study will involve myself asking you a set of semi-structured questions and possibly others, if necessary. The duration of the interview will be approximately 60 minutes. There may be a request for a follow-up interview, should I need clarification on any points. Should this be necessary, I will contact you and request your consent for a follow-up. You are free to deny this request without consequences or prejudice.

Your answers to the questions will be recorded using an electronic device for the purpose of documenting your responses to ensure that none of the results of this study are fabricated. Your identity will not be revealed at any time and your responses will be coded during the transcription process. The study will not provide any direct benefits to you, the participant, but it will help in gaining more knowledge on the experience of burnout.

Although the researcher strives to avoid harm to any participant, should you find yourself negatively affected, emotionally or psychologically, during or after the study, please contact the researcher (Kerry Anderson) or the project leader (Prof. Duncan Cartwright) so that the necessary assistance can be provided. Although the current sample is not considered a

vulnerable group, should any participants experience any form of psychological distress resulting from participation in this research, they will be referred to the UKZN Psychology Clinic or another suitable psychological service.

Your name or address will **NOT** be recorded in this study – only a study number will be assigned. Confidentiality of your personal/ clinical information will be protected at all times.

In the event of any problems, concerns or questions, you may contact:

1. Project Leader: (Prof. Duncan Cartwright) Tel: (031-260 2507)
2. Student Researcher: (Kerry Anderson) Cell: (083 776 0772)
3. HSSREC Research Office: University of KwaZulu-Natal, Westville Campus. Tel: (031-260 8350)
4. UKZN Psychology Clinic: Room B18, Lower Ground Floor, Memorial Tower Building, King George V Avenue, Durban. Tel: (031-260 7425)

Consent Form for the ProQOL Version 5 Questionnaire:

I, ____ have been informed about the questionnaire entitled "Professional Quality of Life scale" and I hereby ***consent / do not consent*** to the researcher using my scores for the questionnaire as a tool for inclusion criteria.

- I understand the purpose and procedures of the questionnaire.
- I have been given an opportunity to ask questions about the questionnaire and have had answers to my satisfaction.
- I understand that my answers will be kept confidential at all times and that the scores will only be used to gauge my applicability for the study.
- I declare that my participation is entirely voluntary and that I may withdraw at any time.
- If I have any further questions, concerns or queries related to the questionnaire I understand that I may contact the researcher.
- If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study then I may contact:

Prof. Duncan Cartwright (Project Leader) University of Kwa-Zulu Natal (Howard Campus) at (031-260 2507) or cartwrightd@ukzn.ac.za

Signature of participant: ________________ **Date:** ___________________

Signature of witness: ____________________ **Date:** __________________
(where applicable)

Researchers' Signature: _________________ **Date:** ___________________
(Kerry Anderson)

Supervisors' Signature: _________________ **Date:** ___________________
(Prof. Duncan Cartwright

Administrators' Signature: _______________ **Date:** ___________________

Consent Form for the study:

I, ____ have been informed about the study entitled "The Experience of Burnout among Psychologists" and I hereby ***consent / do not consent*** to participate in the study.

I, ____ hereby ***consent / do not consent*** to have my responses audio-recorded during the interview.

- I understand the purpose and procedures of the study.
- I have been given an opportunity to ask questions about the study and have had answers to my satisfaction.
- I declare that my participation in this study is entirely voluntary and that I may withdraw at any time.
- If I have any further questions, concerns or queries related to the study I understand that I may contact the researcher.
- If I have any questions or concerns about my right as a study participant, or if I am concerned about an aspect of the study then I may contact:

Prof. Duncan Cartwright (Project Leader) University of Kwa-Zulu Natal (Howard Campus) at (031-260 2507) or cartwrightd@ukzn.ac.za

Signature of participant: ________________ **Date:** ________________

Signature of witness: ________________ **Date:** ________________

(where applicable)

Researchers' Signature: ________________ **Date:** ________________

(Kerry Anderson)

Supervisors' Signature: ________________ **Date:** ________________

(Prof. Duncan Cartwright)

Administrators' Signature: ________________ **Date:** ________________

10.2 Appendix B – Professional Quality of Life Scale (ProQOL)

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue
(ProQOL) Version 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 24 months (2 years).

1=Never	**2=Rarely**	**3=Sometimes**	**4=Often**	**5=Very Often**

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

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10.3 Appendix C – Interview Schedule

Introduction:

The aim of my research is to find out how you experienced burnout. What you think lead to it, how it felt, how you recognised it when it was occurring, how it impacted your life, how it relates to your self-concept and how your context influenced the experience.

There are no right or wrong answers, everything I am asking is about YOUR opinion or feelings on the matter. Thus, your openness and honesty is much appreciated. If at any point you do not want to answer a question or go further in an explanation please stop. If you do not understand a question, please feel free to ask for clarification.

I will now go through the consent form with you.

Do you have any questions before we start?

Questions:

1. Can you tell me about a time when you experienced burnout?

2. What do you think lead to you being burnt out?

   Prompts:
   - What about yourself do you think might put you at risk for burnout? (Internal). Why do you think this puts you at risk?
   - What part of your job do you think puts you at risk for burnout? (External). Why do you think this puts you at risk?

3. From your experience, do you think burnout is a process?

   Prompts:
   - How did it progress? Can you describe the stages you went through (if any)?

4. When did you realise you were burnt out?

   Prompts:
   - Did you recognise it in yourself or did someone else notice?

- Was it a specific event?
- Why do you think this made you realise?

5. How did burnout affect your life?

   Prompts:

   - How did burnout affect your work?
   - How did you feel physically? Did it make you sick?
   - How would you describe your emotions during this time?
   - How did burnout affect your home life?
   - Did you notice any changes in your relationships? (with children, friends, significant other)
   - Why do you think it affected you this way?

6. What did you do when you recognised that you were burnt out?

   Prompts:

   - What strategies did you use?
   - How did you cope?
   - Why do you think you chose these strategies?

7. What does burnout mean to you?

   Prompts:

   - How would you describe it?
   - Why do you think that these (elements mentioned) are important to consider?

8. Do you think there is a stigma around burnout in this profession?

   Prompts:

   - Why do you think this stigma exists?
   - Do you think this stigma affects you personally?
   - Do you think it affected the way you thought about yourself when you realised you were burnt out?

9. Did experiencing burnout change way you view yourself?

   Prompts:

   - How did it affect the way you see yourself?

- Why do you think it affected you this way?

10. How do think your personal context influences your experience of burnout?

    Prompts:

    - Do you think South African psychologists experience burnout differently to psychologists in other parts of the world?
    - Why do you think that is?
    - What do you think makes the experience different / similar?

11. After all that has been discussed, if you had to summarise what burnout means to you, how would you describe it?

12. Is there anything else you feel is important to mention about your experience of burnout, that you haven't mentioned already?