Psychological Practitioner Workplace Wellbeing

Elisabeth Mary Ann Summers

2018

Supervised by:

Professor Reg Morris

Thesis submitted in partial fulfilment of the requirement for the degree of Doctor of Clinical Psychology at Cardiff University and the South Wales Doctoral Programme in Clinical Psychology

Summary of Thesis

There is extensive research detailing the strong link between healthcare professional wellbeing and the delivery of dignified, safe patient care. While a career as a psychological practitioner is often perceived as fulfilling, it is thought to also generate professional and personal strains which may impact on wellbeing.

Paper 1 presents a systematic review examining the prevalence of burnout among practitioner psychologists and the relationship between burnout and specific personal demographic and work-related variables: age, years in service, working hours, gender and work setting. This yielded eight studies meeting the inclusion criteria. Study quality was assessed and data was extracted. Due to inconsistencies with defining and assessing burnout, the overall prevalence of burnout in this population could not be validly determined. However, findings suggest that younger, less experienced individuals and those working longer hours appear to be at increased risk of burnout and/or associated dimensions.

Paper 2 presents the development and validation of a new measure to assess psychological practitioner workplace wellbeing. The measure was developed in five stages, followed by an examination of the psychometric properties of the measure utilising a sample of 400 psychological practitioners. The measure was shown to have high internal consistency, high test-retest reliability and high construct validity. Exploratory factor analysis produced a set of six factors explaining 62.1% of the variance in the measure. Results indicate the measure has favourable psychometric properties for the effective assessment of the workplace wellbeing of psychological practitioners.

Paper 3 presents a critical appraisal of the research process. This paper includes a reflection on the methodologies used and conclusions drawn, implications of the findings and suggestions for future research. Aspects of personal and professional competency development are also considered.

Declaration

This work has not been submitted in substance for any other degree or award at this or any other university or place of learning, nor is being submitted concurrently in candidature for any degree or other award.

Signed …………………………………………… (candidate)   Date …………………………

STATEMENT 1

This thesis is being submitted in partial fulfilment of the requirements for the degree of DClinPsy.

Signed …………………………………………… (candidate)   Date …………………………

STATEMENT 2

This thesis is the result of my own independent work/investigation, except where otherwise stated.

Other sources are acknowledged by explicit references. The views expressed are my own.

Signed …………………………………………… (candidate)   Date …………………………

STATEMENT 3

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

Signed …………………………………………… (candidate)   Date …………………………

STATEMENT 4: PREVIOUSLY APPROVED BAR ON ACCESS

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loans **after expiry of a bar on access previously approved by the Academic Standards & Quality Committee.**

Signed …………………………………………… (candidate)   Date …………………………

Acknowledgements

I would like to start by thanking my academic supervisor, Professor Reg Morris, for his invaluable guidance, support and patience through this process. Thank you too, to my external supervisor, Dr. Gita Bhutani, and to Dr. Amra Rao who have been a great support from afar and who have encouraged and assisted me to disseminate this research.

I would also like to express my sincere gratitude to all the clinicians who took part in this research and for the interest that was shown. Without your input this would not have been possible. In particular a big thank you to Charlie, who has offered words of wisdom, encouragement and support for many years.

A heartfelt thank you to you my parents. My Mum who has tirelessly listened and reassured, and my Dad who always tells me how proud he is. Thank you for always believing in me and encouraging me to follow my passions.

I could not have completed this research without the incredible support, patience and grounding from my partner, Will. I cannot thank you enough.

Finally, I would like to thank my Grandmother and Anna who have always been by my side. The strength, determination and courage you both showed in your lives has inspired me to never give up. I hope I make you proud.

Contents

List of Tables Paper 1

List of Figures Paper 1

List of Tables Paper 2

Paper 1 has been prepared in accordance with the author guidelines for submission to the journal Clinical Psychology & Psychotherapy (Appendix A), with the exception of the inclusion of tables within the main text.

Paper 1: Prevalence and correlates of burnout in practitioner psychologists: Findings from a systematic review

Word count (excluding figures/tables): 7953

Abstract

Background: Healthcare professional burnout has potentially significant consequences for professionals, patients and organisations. In addition to the personal impact, burnout has been associated with reduced patient care and increased absenteeism and staff turnover. While a career as a practitioner psychologist is often perceived as fulfilling, it is thought to also generate professional and personal strains.

Objectives: This systematic review aims to explore the prevalence of burnout and specific personal and work-related correlates of burnout in practitioner psychologists.

Method: A systematic review of quantitative studies, utilising a validated measure of burnout in practitioner psychologists, published in English between 1988 and 2017.

Data sources: The databases PsycINFO, ASSIA, Web of Science and Scopus were searched.

Results: Eight eligible studies were reviewed. There are currently no binding definitions or diagnostic criteria for burnout. Therefore, the overall prevalence of burnout among practitioner psychologists cannot be validly determined. However, low to moderate associations were observed between some dimensions of burnout and some personal and occupational factors. Overall, younger, less experienced individuals and those working longer hours appear to be at increased risk of burnout and/or associated dimensions, while those working in private practice appear to be at lower risk of burnout and/or associated dimensions.

Conclusions: We do not yet know the extent to which burnout is a problem, because we are unable to determine how many professionals are 'burned out'. The current review highlights

the necessity for more robust definitions and sound, generalisable research within this population.

Key Practitioner Message

- Healthcare professional burnout has been found to have significant consequences for professionals, patients and organisations.

- There are currently no binding definitions or diagnostic criteria of burnout and therefore overall prevalence of burnout among practitioner psychologists cannot be validly determined.

- Younger, less experienced individuals and those working longer hours appear to be at increased risk of dimensions associated with burnout. Individuals working in private practice appear to be at lower risk.

- A robust definition of burnout and associated psychometric measures are required to enable the effective assessment of burnout in healthcare professionals.

Keywords: Burnout, practitioner psychologist, health professional, psychotherapy, systematic review

Introduction

Burnout

The concept of *burnout* is thought to have been independently introduced by both

Freudenberger (1974) and Maslach (1976), as a term to describe a reaction to occupational

stress. Freudenberger and Maslach coined the term following the identification of similar

psychosocial reactions from volunteers working with social problems in underprivileged citizens

(Kristensen, Borritz, Villadsen & Christensen, 2005). The term burnout was initially a non-

theoretical concept. However, it soon became a metaphor for a range of psychosocial

experiences that individuals, employed in human service professions, may encounter

(Kristensen et al., 2005).

Maslach and Jackson (1981) defined burnout as an internal emotional reaction (illness)

caused by external factors: "a syndrome of emotional exhaustion and cynicism that occurs

frequently among individuals who do 'people-work' of some kind" (p. 99). Freudenberger

(1980) proposed burnout is "brought about by devotion to a cause, way of life or relationship

that failed to produce the expected reward" (p. 13) and Maslach, Schaufeli, and Leiter (2001)

proposed it is a "response to chronic interpersonal stressors on the job" (p. 399).

Burnout can be thought of as a specific form of psychological stress, rather than an

illness, that is thought to develop gradually and may remain unnoticed for some time

(Ruotsalainen, Verbeek, Mariné & Serra, 2015). In healthcare professional populations,

burnout, as defined by Maslach and colleagues, is characterised by three simultaneously

existing dimensions, (1) *emotional exhaustion*, the depletion of emotional reserves, energy loss

and feeling less able to experience emotion related to work; (2) *depersonalisation*, the distancing from patients and negative or cynical attitudes and feelings towards patients, and (3) *lack of personal accomplishment*, negative self-evaluation, particularly in relation to patient work, and feelings of dissatisfaction with work accomplishments and achievements (Maslach et al., 1996; Maslach & Jackson, 1981).

Although Maslach and colleagues' definition of burnout is the most prevalent in the literature (Maslach, Jackson & Leiter, 1996; Maslach, Schaufeli & Leiter, 2001; Schaufeli, Leiter & Maslach, 2009) an alternative theory is that burnout is a form of depression rather than a distinct phenomenon. When Freudenberger (1974) initially introduced the concept, it was proposed that when experiencing burnout "the person looks, acts and seems depressed" (p. 161). More recently, Bianchi, Schonfeld, and Laurent (2015) conducted a review of the burnout-depression overlap, proposing the distinction is conceptually fragile and the evidence for the singularity of burnout as a concept is inconsistent.

It is important to consider the major role that social context and culture play in the way burnout is viewed. For example, Schaufeli and Enzmann (1998) noted that North American samples tended to have higher levels of emotional exhaustion and depersonalisation than similar European samples, measured using Maslach Burnout Inventory (Maslach & Jackson, 1986, see below). They proposed that while this may demonstrate higher rates of burnout in American populations, it may highlight the higher social acceptability of exhibiting burnout symptoms in the United States than in Western samples. Wilmar et al. (2009) also acknowledged that in some countries, a 'formal' diagnosis of burnout may present the possibility for an individual to personally profit, for example, through financial compensation or

14

psychotherapeutic intervention. In other countries however, the concept of burnout is not deemed to be a formal diagnosis requiring specific intervention or financial recompense.

Measures of Burnout

The Maslach Burnout Inventory (MBI; Maslach & Jackson, 1986) was the first standardised instrument designed to assess burnout and is the most widely used measure in burnout literature. The MBI has been used extensively internationally and has been translated into more than thirty different languages (Maslach et al., 2017). The original MBI was designed for use with human service professionals. However, since the development of the initial measure, additional versions of the MBI have been developed to assess burnout in other professions, for example, the MBI General Survey (MBI-GS) for those occupations that do not involve frequent direct personal contact with service recipients (Maslach, Jackson & Leiter, 2017).

The original MBI is now named the MBI Human Services Survey (MBI-HSS). This measure consists of 22 questions containing three subscales; *Emotional Exhaustion* (EE), *Depersonalization* (DP) and *Personal Accomplishment* (PA). These subscales relate to Maslach and colleagues' definition of burnout (Maslach, Jackson & Leiter, 1996; Maslach, Schaufeli & Leiter, 2001). For both the EE and DP subscales, higher scores are associated with higher levels of burnout. Conversely, low PA subscale scores are associated with burnout. Maslach and Jackson (1981) reported internal consistency coefficients as .89, .77, and .74, respectively, for

the EE, DP, and PA subscales of the MBI-HSS based on scores from a sample of human service personnel.

Despite its widespread use, the MBI-HSS has been subject to criticism relating to its conceptualisation (Kristensen et al., 2005). For example, as previously noted, the definition of burnout according to Maslach and colleagues suggests burnout is characterised by the simultaneous occurrence of emotional exhaustion, depersonalisation and a lack of personal accomplishment. However, Maslach et al. (2017) suggest the three subscales of burnout (EE, DP and PA) should be measured independently, and factor analyses have confirmed them as three distinct and different dimensions. Kristensen et al. (2005) propose caution should be applied when interpreting research that claims to provide an overall burnout score as the three different components should be studied independently.

In 1986, Maslach and Jackson proposed cut-off scores for each subscale to identify individuals with high, moderate, and low levels of burnout. These were derived from dividing the normative sample into three equal-sized groups, identifying the 33rd and 66th percentiles. However, caution against the use of cut-off scores for diagnostic purposes was also proposed (Maslach & Jackson, 1986; Maslach et al., 2017). Despite this, the publication of cut-off scores has served as a motivating factor for their use in the classification of burnout. For example, in a systematic review assessing prevalence of burnout in emergency department nurses, Adriaenssens, De Gucht and Maes (2014) noted the cut-off scores that indicate burnout on the MBI-HSS subscales for mental health workers, proposed by Maslach and Jackson (1986), are: EE ≥ 21, DP ≥ 8, PA ≤ 28, and used these cut-off scores to evaluate the prevalence of burnout within a nursing population.

Another validated measure of burnout frequently used with healthcare professionals is The Copenhagen Burnout Inventory (CBI), developed in response to criticisms of the MBI-HSS (Kristensen et al., 2005). The CBI has been translated into many different languages and has been used internationally in a range of services and professional groups. This generic measure, unlike the primary version of the MBI, was designed to have utility across different professional domains. The authors propose fatigue and exhaustion are at the core of burnout, with an additional key feature being "the *attribution* of fatigue and exhaustion to specific *domains* or spheres in the person's life" (Kristensen et al., 2005, p. 197).

The CBI is a 19-item measure containing three categories: personal burnout, work-related burnout and client-related burnout. Higher scores indicate higher levels of burnout, with overall burnout being indicated by a total CBI score ≥ 50. The personal burnout scale measures the degree of physical and psychological fatigue and exhaustion experienced by a person regardless of whether the person is working or not. The work-related burnout scale measures the degree of physical and psychological fatigue and exhaustion related to work. The client-related burnout scale measures the degree of physical and psychological fatigue experienced by people who work with recipients in human services and is applicable to people who work with 'clients'. The three scales have been shown to have high reliability for use in various populations, with Cronbach's α scores of .87 for the personal burnout scale, .87 on the work-related burnout scale and .85 on the client-related burnout scale (Kristensen et al., 2005).

Prevalence, Associations and Implications of Burnout in Healthcare Professionals

There is considerable evidence proposing the presence of burnout among healthcare professionals, including clinical psychologists (Cushway & Tyler, 1994); nurses (Adriaenssens et al., 2015); and physicians (Gregory, & Menser, 2015), affecting those employed in a range of healthcare settings, including intensive care units (van Mol, Kompanje, Benoit, Bakker & Nijkamp., 2015); oncology services (Eelen et al., 2014); and correctional facilities (Lambert & Paoline, 2008).

A variety of personal factors have been associated with an increased risk of burnout in healthcare professionals, including low self-esteem and neuroticism (Maslach et al., 2001). Additionally, as discussed, depressive symptoms have been observed in individuals presenting with burnout. Bianchi, Schonfeld and Laurent (2014) noted that up to 90% of the individuals experiencing burnout (n = 67) met criteria for a provisional diagnosis of depression. Burnout has also been associated with increased risk of suicidal ideation in medical students (Dyrbye et al., 2008) and anaesthesiologists (Özkan, Karaman, Öztürk, Ahun, & Selmi, 2015).

As well as the undesirable personal impact, burnout among healthcare professionals has been found to have a negative impact upon patient care (Rothenberger, 2017). Correlations with negative effects that may impact patients have been identified, including reduced quality of patient care (Hall, Johnson, Watt, Tsipa & Connor, 2016; Williams, Manwell, Konrad, & Linzer, 2007), decreased patient satisfaction (Vahey, Aiken, Sloane, Clarke & Vargas, 2004), and increased errors (Fahrenkopf et al., 2008). At an occupational and wider societal level, there are significant economic impacts associated with healthcare professional burnout, as indicated by

data on absenteeism (Borritz et al., 2006), presenteeism (Demerouti, Le Blanc, Bakker, Schaufeli, & Hox, 2009) and staff turnover (Leiter & Maslach, 2009; Johnson et al., 2018).

Burnout in psychotherapists has been explored since the early 1980's. At this time, Farber and colleagues focussed on the level of burnout, satisfactions, stresses and personal effects of psychotherapeutic work in a range of psychotherapists, including professional psychologists. They proposed that while a career as a psychotherapist is perceived as fulfilling, it may also generate professional and personal strains (Farber, 1983a; Farber 1983b; Farber & Heifitz, 1981; Farber & Heifitz, 1982). For clinical psychologists, it has been reported that burnout is more likely in younger individuals and females (e.g. Cushway & Tyler, 1994; Martin-Johnson, 2016). In addition to the challenges related to clinical work, specific organisational and systemic factors have been associated with practitioner psychologist burnout. For example, Rupert and Morgan (2005) highlighted that clinical and counselling psychologists frequently practice in settings with high systemic pressures, including limited resources and excessive administrative demands. The current review examines the literature relating to such associations.

It is important to note that despite the implications and associations between burnout and a number of factors, it is impossible to fully determine causality because of the inability to control potential confounding variables, or the direction of influence.

Objectives

There is a relative dearth of research investigating burnout among practitioner psychologists in comparison to burnout among other medical professionals (e.g. nurses and

physicians). Considering the potential impact of burnout for healthcare professionals,

patients/clients and the wider society, the purpose of the current review was (1) to identify

prevalence of burnout in practitioner psychologists working within a clinical setting, irrespective

of patient/client group and country of practice and (2) to identify specific personal and work-

related correlates of burnout within this population.

<center>**Method**</center>

The systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Moher, Liberati, Tetzlaff & Altman, 2009) to ensure reporting standards were adhered to.

Search Strategy

A literature search was conducted on four electronic databases in March 2018 (see Table 1). Publication year was restricted only by individual database limits. Initial scoping of published systematic reviews and literature identified commonly used search terms for inclusion.

The title 'psychologist' is not a protected title within the UK, whereas practitioner psychologist and registered psychologist are, and those using these titles are required to be registered with the Health Care Professionals Council (HCPC). In addition to these generic titles, there are seven domain specific titles used by individual HCPC registered psychologists: clinical psychologist, counselling psychologist, educational psychologist, forensic psychologist, health psychologist, occupational psychologist and sport and exercise psychologist. Internationally, practitioner psychologists may alternatively use the titles: licensed psychologist or professional psychologist. Considering the professional titles and inclusion criteria (see below), the following search terms were used:

<center></center>

"clinical psychologist*" OR "counsel* psychologist*" OR psychologist* OR "practitioner

psychologist*" OR "psychological practitioner*" OR "registered psychologist*" OR "forensic

psychologist*" OR "health psychologist*" OR "health psychologist*" OR "occupational

psychologist*" NOT "school psychologist*") AND (burnout OR "burn* out" OR "burn out" OR

"stress".

     The terms were searched in title, abstract, heading word, keyword, topic or key concept.

Owing to some terms being commonly used within literature, for example, *psychologist,* some

terms were limited to being present in article title and/or abstract only. Where possible the

term "school psychologist" was excluded from the search terms owing to the volume of

research within this population. Additionally, although educational psychologists and sports

and exercise psychologists are practitioner psychologists, these terms were not used within the

searches due to these professionals not working in clinical settings. For an example of full

search terms used in PsycINFO see Appendix B.

Table 1

Electronic Database Searches and Identified Records

Database	Records identified
PsycINFO (1806 – March 2018)	768
ASSIA (1987 – March 2018)	132
Web of Science (1900 – March 2018)	325
Scopus (1823 – March 2018)	487
Total (N)	1712

Inclusion and Exclusion Criteria

This systematic review included studies that (1) were quantitative studies with a cross-sectional design (to examine prevalence of burnout) (2) reported at least the prevalence of burnout, (and specific personal and/or work-related correlates where appropriate) in qualified practitioner psychologists (job titles: clinical psychologist, counselling psychologist, forensic psychologist, health psychologist, occupational psychologist, practitioner psychologist, registered psychologist), working with clinical populations (3) utilised a validated quantitative measure of stress or burnout (4) were published research (excluding case-studies, theses, book chapters and manuals), in English language.

Studies were excluded if (1) practitioners were employed within education, sporting or research settings (non-clinical) (2) studies included professionals other than practitioner psychologists (3) studies assessed vicarious trauma, secondary trauma or emotional distress (e.g. depression and anxiety) and not burnout.

Study Screening and Selection

Following the removal of duplicate records (n=593), the titles and abstracts of identified records (n= 1119) were screened by the researcher to identify relevant articles. Full texts were obtained for records where it was unclear if the study met the inclusion criteria from the abstract alone (n= 14). Six studies were subsequently excluded, resulting in eight studies for inclusion. Reference lists for those articles which matched the inclusion criteria were also examined for additional relevant studies. Five additional articles were identified within

reference lists and assessed for potential inclusion. However, none of these articles met the

inclusion criteria. A diagram of the systematic review selection process and reasons for removal

of records is shown in Figure 1.

Figure 1

PRISMA flow diagram indicating the literature search procedure, study screening and selection
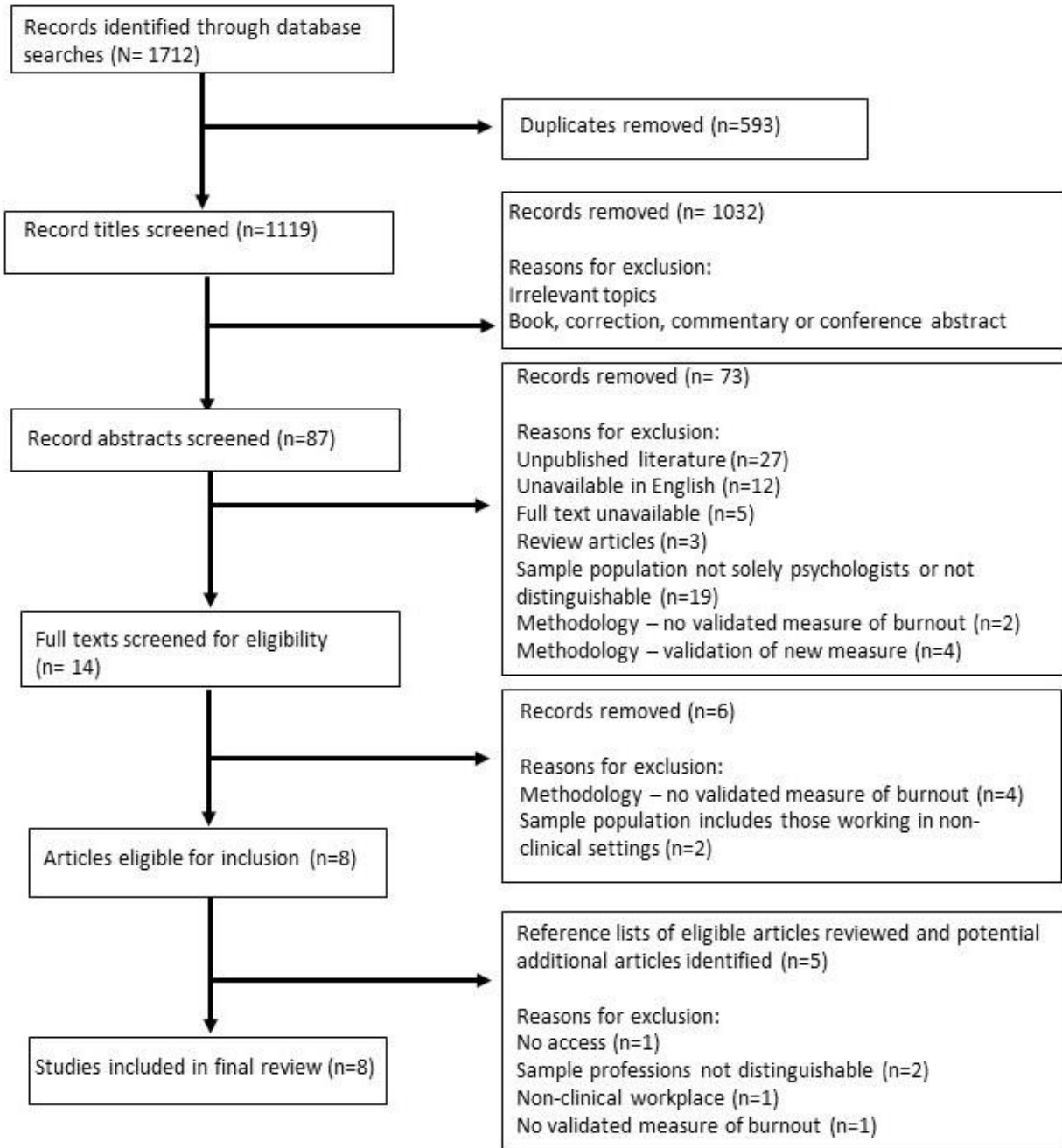
Quality Assessment

There is no single recommended approach for assessing the quality of cross-sectional studies (Centre for Reviews and Dissemination, 2009). Commonly used critical appraisal tools were not deemed to be appropriate for use in this review because of the inclusion of inappropriate or insufficient criteria. Therefore, to ensure an appropriate tool was used, the methodological quality of the eight selected studies was evaluated using a quality assessment tool developed by the researcher (Appendix C). This assessment tool was based on criteria of importance identified by Greenhalgh and Brown (2014, cited in Boland, Cherry & Dickson, 2014) and The Joanna Briggs Institute guidelines for cross-sectional and prevalence studies (The Joanna Briggs Institute, 2016; 2017), and was designed to evaluate the quality of the included studies based on a numerical scoring system.

The tool assessed 11 aspects of each study including design, sampling and population, validity of measures, analysis and discussion of findings and conclusions drawn. For each of the 11 criteria, each study was given a score of 2 if a criterion had been fully addressed and clearly reported; 1 if a criterion had been partially addressed or reporting was unclear; and 0 if a criterion was not addressed, poorly addressed or not applicable. Each study was given a total score based on the sum of the scores from each of the 11 criteria enabling clear differentiation between higher and lower quality studies. Table 2 shows the quality assessment scores for each study included in the review. High scores indicated a higher quality methodology based on the assessment tool criteria.

Both human error and bias are possible when one reviewer screens studies. Therefore, the primary researcher conducted quality assessment and data extraction for all studies and additionally an independent reviewer conducted a quality assessment of 2 papers (25%). Any discrepancies between the two reviewers were discussed and an agreement was reached. All eligible studies were included in the review, regardless of the quality score they received.

Table 2

Quality Rating Assessment Results

	Aims/ hypotheses	Represen- tative sample	Inclusion/ exclusion criteria	Recruit- ment	Sample size	Response rate	Measure quality	Missing data	Analysis and results	Conclu- sions	Future research	Total quality score
Ackerley, Burnell, Holder & Kurdek (1988)	1	1	2	2	1	1	1	0	2	2	1	14
Berjot, Altintas, Grebot & Lesage (2017)	1	1	2	2	2	0	2	0	2	1	1	14
Di Benedetto & Swadling (2014)	2	1	1	1	1	0	2	2	2	2	2	16
D'Souza, Egan & Rees (2011)	2	1	1	1	2	0	2	0	2	2	0	13
Emery, Wade & McLean (2009)	2	1	1	2	1	2	1	1	2	2	2	17
Rupert & Kent (2007)	1	1	2	2	1	2	1	0	2	1	2	15
Rupert & Morgan (2005)	1	1	2	2	1	1	1	1	2	1	0	13
Rupert, Stevanovic & Hunley (2009)	2	1	2	2	1	2	2	1	2	2	2	19

Results

Data Extraction

Data extraction and quality assessment were conducted at separate time to reduce

"data extraction bias" (Petticrew, & Roberts, 2008, p.155), in which the reviewer may extract

information while applying differential judgements of quality or methodological adequacy in

accord with their own views. A meta-analysis of results was not feasible because of

inconsistencies in methodology, measures and the reporting of results. Therefore, a critical

appraisal of the studies was conducted in a narrative synthesis format.

Quality Assessment

Overall, all studies were of an average quality. A total quality score for each study,

enabling comparison between studies, is provided in Table 2. However, each quality criterion

may be considered differentially important and therefore a weighting method may be more

appropriately utilised to calculate total quality scores. This method risks additional bias without

appropriate validation due to subjectivity. Therefore, for this review, the scores provide a

broad, but non-validated, overview of study quality. Based on the quality assessment tool

created, the studies considered to be of highest quality were: Emery et al. (2009) and Rupert et

al. (2009) and lowest quality were: D'Souza et al. (2011) and Rupert and Morgan (2005).

Participant recruitment was conducted via a range of methods, including random

mailing to members of professional bodies (Ackerley et al., 1988; Rupert & Kent, 2007; Rupert

& Morgan, 2005; Rupert et al., 2009) and professional registers (Di Benedetto & Swadling, 2014; Emery et al., 2009). Some participants were also recruited via 'word of mouth' and 'professional acquaintances' (Berjot et al., 2017; Di Benedetto & Swadling, 2014; D'Souza et al., 2011).

No studies fully reported the representativeness of the study sample, meaning generalisability of findings should be made with caution. Additionally, many studies did not sufficiently explain the management of missing data and three studies did not report response rate. No papers described the characteristics of psychologists that were approached to participate in the study but chose not to.

Three studies (Ackerley et al., 1988, Berjot et al., 2017, Di Benedetto & Swadling, 2014) reported the percentage of participants that presented with differing levels of burnout, based on norms for mental health professionals proposed by Maslach and Jackson (1986) or Kristensen et al. (2005). The remaining studies reported mean burnout scores, with Rupert and Kent (2007) and Rupert and Morgan (2005) reporting the level of burnout associated with mean scores.

The majority of the studies were balanced in the reporting of conclusions, acknowledging limitations, including participant representation and methodological issues. Areas for future research were fully addressed in four studies (Di Benedetto & Swadling, 2014; Emery et al., 2009; Rupert & Kent, 2007; Rupert et al., 2009) and partially addressed or omitted by the remaining half of the studies.

Characteristics of Included Studies

Characteristics of reviewed studies are summarised in Table 3. Studies were conducted between 1988 and 2017. All studies had a cross-sectional design and were peer-reviewed publications. Four studies were conducted in the USA., three in Australia and one in France. All participants were professional psychologists. Professional titles varied between studies; 'licenced psychologist', 'professional psychologist', 'registered psychologist', 'clinical psychologist' and 'counselling psychologist'. All participants worked within clinical settings in a range of services.

Sample sizes ranged from 87 to 664 participants. Response rates were detailed in five of the eight studies, ranging from 35.4% to 49.6%. The distribution of age and years of experience were fairly consistent across studies. However, the distribution of gender ranged from 27% to 90.1% female (see Table 3).

All studies utilised a validated measure of burnout, either the MBI-HSS (Ackerley et al., 1988; Berjot et al., 2017; Emery et al., 2009; Rupert & Kent, 2007; Rupert & Morgan, 2005; Rupert et al., 2009) or the CBI (Di Benedetto & Swadling, 2014; D'Souza et al., 2011). Berjot et al., 2017 utilised the French-Canadian Version of the MBI, validated in the French language (Dion & Tessier, 1994).

Summary of Main Findings

Table 4 provides a summary of results from the eight included studies.

Table 3

Study Characteristics

Authors (year) Country of study	Sample size (% response rate)	Profession (%)	Work setting (%)	% Female	Participant age	Years of experience	Burnout measure
Ackerley et al. (1988) USA	562 (35.4)	Licensed psychologists (100)	Private practice (61) Psychiatric hospital (10) Community centre (7) Outpatient clinic (7) General hospital (6) Other (9)	27	*M* = 44.2 years SD = 8.5 Range = 31-72	*M* = 18.8 years Range = 1-43	MBI (1986)
Berjot et al. (2017) France	664 (NR)	Professional psychologists (100)	Public hospital (43.7) Non-profit organisations (20.9) Governmental organisations (10.7)	90.1	*M* = 35.4 SD = 9.83	*M* = 8.01	French- Canadian version MBI-HSS (Maslach et al., 1996) French translation (Dion & Tessier, 1994)
Di Benedetto & Swadling (2014) Australia	167 (NR)	Registered psychologists (100)	Private practice (52.1) Public sector (47.9)	86.8	*M* = 42.47 years SD = 11.64 Range = 24-68	NR	CBI (Kristensen et al., 2005)

Authors (year) Country of study	Sample size (% response rate)	Profession (%)	Work setting (%)	% Female	Participant age	Years of experience	Burnout measure
D'Souza et al. (2011) Australia	87 (NR)	Clinical psychologists (100)	Both public sector and private practice (95%)	86	20-30 years (21%) 31-40 years (37%) 41-50 years (23%) 51-60 years (12%) 60+ years (7%)	1-5 years (39%) 6-10 years (29%) 11-15 years (14%) 16-20 years (6%) Over 20 years (12%)	CBI (Kristensen et al., 2005)
Emery et al. (2009) Australia	190 (39)	Clinical psychologists (100)	Government (45.3) Non-government (2.1) Private practice (28.4) Government and private practice (18.4) Non-government and private practice (5.3)	71.6	20-29 years (17.4%) 30-39 years (26.3%) 40-49 years (25.3%) 50-59 years (21.1%) 60+ years (9.5%)	< 5 years (31.1%) 5-9 years (24.7%) 10-14 years (13.7%) 15-19 years (10%) 20+ years (20.5%)	MBI-HSS (Maslach et al., 1996)
Rupert & Kent (2007) USA	595 (49.6)	Clinical psychologists (83.2) Counselling psychologists (16.8)	Solo independent practice (57.31) Group independent practice (15.97) Agency (25.71) N/A† (1.01)	58.3	M = 51.98 SD = 8.21	M = 17.91 SD = 8.07	MBI-HSS (Maslach et al., 1996)

Authors (year) *Country of study*	Sample size (% response rate)	Profession (%)	Work setting (%)	% Female	Participant age	Years of experience	Burnout measure
Rupert & Morgan (2005) *USA*	571 (47.6)	Clinical psychologists (80) Counselling psychologists (20)	Solo independent practice (47.98) Group independent practice (26.62) Agency (22.77) NA† = (2.63)	54.3	*M*= 51.61 *SD* = 8.27	*M* = 16.93 *SD* = 7.66	MBI-HSS (Maslach et al., 1996)
Rupert et al. (2009) *USA*	487 (40.58)	Licensed psychologists (100)	Agency (20.4) Solo independent practice (58) Group independent practice (21.6)	57.9	*M* = 54.1 *SD* = 7.9	*M* = 19.6 *SD* = 7.8	MBI-HSS (Maslach et al., 1996)

Note. NR = Not recorded; M = mean; SD = standard deviation

Agency = psychiatric or general hospitals, community centres, outpatient clinics, counselling centres; Private practice = Independent practitioners, not working within an organisation; Government = public sector; Solo independent practice = private practitioners not working within an organisation; Group independent practice = practitioners working privately within a private group organisation/ as an affiliate/ independent contractor/employee.

† Respondents checked more than one setting for primary place of work and were therefore not categorised in to one of three work-setting categories

Table 4

Study Aims and Findings

Authors (year)	Study aim	Burnout prevalence	Key personal and work-related burnout correlates
Ackerley et al. (1988)	Investigate prevalence of burnout in licensed psychologists and correlates of burnout.	**MBI-HSS: *M*(SD) % burnout** EE: 19.44 (9.31) 32.7% moderate burnout†; 39.9% high burnout† DP: 6.31 (4.48) 24.7% moderate burnout; 34.3% high burnout† PA: 42.27 (4.52) 3.8% moderate burnout†; 0.9% high burnout†	No significant correlation between gender and EE or gender and PA. No significant correlation between years of service and PA. Those in private practice experienced less EE: $F(1, 510) = 4.70$, $p < .03$; less DP $F(1, 510) = 15.86$, $p < .03$; and more PA: $F(1, 510) = 43.64$, $p < .03$, than those in the public sector. Significantly higher mean scores on each subscale of MBI compared to the norms for mental health workers (Maslach & Jackson, 1986).

Authors (year)	Study aim	Burnout prevalence	Key personal and work-related burnout correlates
Berjot et al. (2017)	Investigate prevalence of burnout among French psychologists and examine an alternative tool for cut-off scores using cluster analysis.	**MBI-HSS: _M_(SD) % Burnout** EE: 24.50 (9.49) 63.1 % burnout† DP: 9.41 (3.80) 65.5% burnout† PA: 33.76 (5.13) 14.6% burnout† Overall burnout: 10.5%†	No correlations reported.
Di Benedetto & Swadling (2014)	Investigate prevalence of burnout and correlates of burnout in Australian psychologists and the role of mindfulness.	**CBI: _M_(SD) % burnout** Personal burnout: 42.37 (19.46) 35.3% Work-related burnout: 34.36 (18.09) 20.4% Client-related burnout: 22.65 (17.03) 12.6% Overall burnout: 33.09 (16.03) 14.4%	Significant negative correlation between years of experience and personal burnout ($r = -.28**$); years of experience and work-related burnout ($r = -.20**$); years of experience and client-related burnout ($r = -.25**$); and years of experience and overall burnout ($r = -.28**$) No significant differences in personal burnout, work-related burnout or client-related burnout between work settings.

Authors (year)	Study aim	Burnout prevalence	Key personal and work-related burnout correlates
D'Souza et al. (2011)	Examine prevalence of burnout and correlates. Explore relationship between perfectionism, stress and burnout.	**CBI Burnout: *M*(SD)** Personal burnout: 25.89 (15.79) Work-related burnout: 33.84 (17.27) Client-related burnout: 39.19 (16.23) Overall burnout: 8%	Significant negative correlation between age and client-related burnout (r = -.25**); age and work-related burnout (r = -.32**); and age and personal burnout (r = -.24**), indicating younger age was related to higher burnout. Significantly higher personal burnout (z = -3.19**) and work-related burnout (z = -3.16**) in females. No significant gender differences in client-related burnout.
Emery et al. (2009)	Examine prevalence of burnout and relationship between demographics, workplace variables and individual factors with burnout.	**MBI-HSS: *M*(SD)** EE: 19.2 (8.6) DP: 4.3 (4.0) PA: 38.9 (5.1)	No association between age and MBI subscales. Higher levels of EE were significantly associated with being a woman (β = .17*) and working primarily for the government (β = -.19*) Higher levels of DP were significantly associated with working primarily for the government (β = -.16*).

Authors (year)	Study aim	Burnout prevalence	Key personal and work-related burnout correlates
Rupert & Kent (2007)	Investigate prevalence of burnout in professional psychologists. Gender and work setting differences in career-sustaining behaviours and burnout.	**MBI-HSS: *M*(SD)** EE: 17.75 (9.16): average burnout range DP: 4.84 (3.76): average burnout range PA: 41.56 (4.88): low burnout range	Significant negative correlations between age and all burnout subscales, with older participants reporting lower EE (r= -.18**) and DP (r= -.12**), and higher PA (r= .12**). The EE subscale revealed a significant Gender X Work setting interaction, $F(2,573)$ = 5.16, p <.006. Women in agency settings reported significantly higher levels of EE than women in either solo independent or group independent practice (p < .01). Women in group independent practice had the lowest levels of EE. However, no significant difference between EE in women in solo independent practice and women in group independent practice. No significant differences in levels of EE for men across work settings. No significant interactions for DP and PA subscales. Significant main effect for gender on the DP subscale, $F(1, 570)$ = 12.19, p < .001; women reported lower levels of DP than men. Significant main effect for work setting on the PA subscale, $F(2, 556)$ = 11.38, p < .001; respondents in solo independent and group independent practice reported higher levels of PA than those in agency settings.

Authors (year)	Study aim	Burnout prevalence	Key personal and work-related burnout correlates
Rupert & Morgan (2005)	Investigate prevalence of burnout and relationship between work setting and levels of burnout among psychologists.	**MBI-HSS: *M*(SD)** EE: 19.99 (9.83): average burnout range DP: 5.21 (4.26): average burnout range PA: 41.64 (4.78): low burnout range	Significant negative correlation between age and EE (r= -.17**) and age and DP (r= -.13**), with older respondents reporting lower EE and DP. The EE subscale yielded a main effect for work setting, $F(2, 544) = 6.65$, $p < .001$, with those in solo independent practice reporting lowest levels and those in agency settings reporting the highest levels of EE. Main effect was qualified by a Gender X Work Setting interaction, $F(2, 544) = 9.52$, $p < .001$. Women in agency settings reported significantly higher levels of EE than women in either solo independent or group independent practice. Men in group independent practice reported significantly higher levels of EE than men in agency settings or solo independent practice. Men reported significantly higher levels of EE than women in both solo independent and group independent practice, but women reported significantly higher levels of EE than men in agency settings. The PA subscale yielded a main effect for work setting, $F(2, 539) = 18.47$, $p < .001$, with respondents in solo independent and group independent practice reporting higher levels of PA than those in agency settings. No work setting differences seen in the DP subscale. The DP subscale yielded a main effect for gender, $F(1, 546) = 8.06$, $p < .005$: with men reporting higher levels of DP than women.

Authors (year)	Study aim	Burnout prevalence	Key personal and work-related burnout correlates
Rupert et al. (2009)	Examine gender and work-setting differences in the experience of burnout among psychologists and role of work-family conflict.	**MBI-HSS: *M*(SD)** EE: 16.41 (8.79) DP: 4.42 (3.69) PA: 42.59 (4.45)	Age significantly negative correlated with burnout; EE (r = -.22), DP (r = -.18), and PA (r =.14) No significant Gender X Work Setting interactions. Significant effect for gender on DP subscale, $F(1, 468) = 8.08$, $p < .005$, $\eta^2 = .02$. With men having significantly higher DP scores than women. Significant main effect for work setting on PA subscale, $F(2, 464) = 8.35$, $p < .001$, $\eta^2 = .04$. Respondents in both solo independent and group independent practice reported a significantly higher sense of PA than respondents in agency settings.

Agency = psychiatric or general hospitals, community centres, outpatient clinics, counselling centres; Private practice = Independent practitioners, not working within an organisation; Government = public sector; Solo independent practice = private practitioners not working within an organisation; Group independent practice = practitioners working privately within a private group organisation/ as an affiliate/ independent contractor/employee.

† Cut off scores based on norms for mental health workers within MBI manual (Maslach & Jackson, 1986)

EE: Emotional Exhaustion; DP: Depersonalisation; PA: Personal Accomplishment

* $p < .05$; ** $p \leq .01$

Prevalence of Burnout

The MBI-HSS subscale information is detailed in Table 5; range of possible scores for MBI-HSS subscales, mean and standard deviation norms based on a heterogeneous group of mental health workers (Maslach et al., 2017), and, while observing the lack of diagnostic validity, the proposed cut-off scores for mental health workers (Maslach & Jackson, 1986).

Table 5

MBI-HSS Subscale Information

MBI-HSS Subscale	M (SD) (Maslach et al., 2017)	Possible score range	Cut-off scores (Maslach & Jackson, 1986)
Emotional Exhaustion	16.89 (8.90)	0 - 54	≥ 21
Depersonalization	5.72 (4.62)	0 - 30	≥ 8
Personal Accomplishment	30.87 (6.37)	0 - 48	≤ 28

All six studies utilising the MBI-HSS reported means and standard deviations for the different subscales of burnout. The mean MBI-HSS, EE subscale score ranged from 16.41 (Rupert et al., 2009) to 24.50 (Berjot et al., 2017), the mean DP subscale score ranged from 4.3 (Emery et al., 2009) to 9.41 (Berjot et al., 2017) and the mean PA subscale score ranged from 33.76 (Berjot et al., 2017) to 42.27 (Ackerley et al., 1988). It is notable that the participant sample in Berjot et al.'s study (2017) had the lowest mean age of all the participant samples within the reviewed studies and overall, indicated the highest level of burnout across all three

subscales. Additionally, the majority of studies observed a higher mean score for the EE and PA subscales than the means proposed by Maslach et al. (2017) for mental health workers.

Despite the lack of validity for the MBI-HSS being used as a diagnostic tool, Ackerley et al. (1988) and Berjot et al. (2017) reported percentage burnout across the three subscales within their studies. However, the cut-off scores used were not provided, reducing the utility of this data. For the EE subscale, Ackerley et al. (1988) reported 39.9% of participants were in the 'high burnout range' and 32.7% in the 'moderate burnout range' and Berjot et al. (2017) reported 63.1% of participants were in the 'burnout range'. For the DP subscale, Ackerley et al. (1988) reported 34.3% in the 'high burnout range' and 24.7% in the 'moderate burnout range', and Berjot et al. (2017) reported 65.5% in the 'burnout range'. For the PA subscale, where low scores are related to higher levels of burnout, Ackerley et al. (1988) reported 0.9% in the 'high burnout range' and 3.8% in the 'moderate burnout range' and Berjot et al. (2017) reported 14.6% in the 'high burnout range'.

Although specific percentages were not reported, Rupert and Morgan (2005) and Rupert and Kent (2007) indicated all reported means for each subscale were within the 'average' or 'low' range of burnout. Rupert et al. (2009) and Emery et al. (2009) solely reported mean scores for each subscale. However, if utilising the proposed cut-off scores (Table 5), the mean scores reported did not indicate burnout on any subscale.

Considering the study quality and participant sample, it is noteworthy that Ackerley et al.'s (1988) study sample contained the highest percentage of male participants, whilst Berjot et al.'s (2017) sample contained the highest percentage of female participants.

Di Benedetto and Swadling (2014) and D'Souza et al. (2011) utilised the CBI (Kristensen et al., 2005) to assess prevalence of burnout. The CBI provides a score for each subscale and an overall score. Considering study quality assessment, the Di Benedetto and Swadling study (2014) scored higher than D'Souza et al.'s study (2011). However, methodologically the studies were of a similar quality overall. Mean scores and standard deviations were reported by both authors. However, percentages of burnout on each individual subscale were only reported by Di Benedetto and Swadling (2014), who reported 35.3% of participants were experiencing personal burnout, 20.4% experiencing work-related burnout and 12.6% experiencing client-related burnout. The mean scores for all burnout subscales were lower in the sample reported by D'Souza et al. (2011). Di Benedetto & Swadling (2014) reported 14.4% of the participants were in the 'overall burnout' range and the remainder in the 'normal range', while D'Souza et al. (2011) reported 8% of the participants were in the 'overall burnout' range and the remainder in the 'normal range'.

Correlates of Burnout

Seven of the eight studies reported correlates associated with burnout. When conducting correlations, Field (2018) proposes a correlation of ±0.1 represents a low association between variables; ±0.3, a medium association between variables; and ±0.5 a strong association between variables. The degree of shared variance between two variables is the square of the correlation coefficient between the variables. Therefore, for example, a correlation of 0.3 signifies less than 10% of the shared variance: 0.3 X 0.3 = 0.09 (9%).

Age and Burnout

Six of the seven studies considered the association between burnout and age (Ackerley et al., 1988; D'Souza et al., 2011; Emery et al., 2009; Rupert & Kent, 2007; Rupert & Morgan, 2005; Rupert et al., 2009), five of which utilised the MBI-HSS to assess burnout. Emery et al. (2009) found no association between age and any MBI-HSS subscales. However, in contrast, four studies reported a low, negative correlation between EE score and age and DP score and age, indicating older participants report lower levels of EE and DP (Ackerley et al., 1988; Rupert & Kent, 2007; Rupert & Morgan, 2005; Rupert et al., 2009). Two studies also identified a low positive correlation between PA score and age (Rupert & Kent, 2007; Rupert et al., 2009), indicating older participants report higher levels of PA than their younger counterparts. Emery et al.'s (2009) study was one of the higher quality studies, but the sample size was more than 50% lower than the other studies utilising the MBI-HSS. Additionally, Emery et al.'s (2009) study was conducted in Australia, in contrast with the other studies being conducted in the USA.

Despite the lower quality of the study, D'Souza et al. (2011) supported the findings of an association between age and burnout, reporting each CBI subscale was negatively associated with age. All age correlations revealed a low correlation between variables, with the expectation of age and CBI work-related burnout which indicated a medium association (D'Souza et al., 2011).

Years in Service and Burnout

Two of the eight studies investigated the relationship between years in service and burnout. Ackerley et al. (1988) reported low negative correlations between EE score and years of service and DP score and years of service, but no significant relationship between PA score and years of service. Using the CBI to assess burnout, Di Benedetto and Swadling (2014) reported stronger, but still low, negative correlations between personal burnout, work-related burnout, client-related burnout, overall burnout and years of experience. Both studies propose that those with higher levels of experience encounter lower levels of burnout.

Working Hours and Burnout

The association between total working hours per week and burnout was reported in three studies (Rupert & Kent, 2007; Rupert & Morgan, 2005; Rupert et al., 2009). All studies found MBI-HSS EE score was positively associated with hours worked. A low positive correlation between DP score and hours worked was also reported in the two studies that showed higher study quality in the quality assessment process, (Rupert & Kent, 2007; Rupert et al., 2009) but not by Rupert and Morgan (2005).

Gender and Burnout

Associations between gender and burnout were explored with both correlation and regression analyses. Ackerley et al. (1998) observed a very low positive correlation between the DP score and gender, but no correlations with the other subscales. Despite this small

correlation, regression analysis found gender was not a predictor of burnout on any of the subscales. Similarly, Emery et al. (2009) found no association between DP or PA and gender. However, conversely, conducting regression analysis with burnout as the outcome, observing a low association between variables, they reported high levels of EE were significantly associated with being a woman. In contrast, Rupert and Kent (2007) and Rupert et al. (2009) conducted analyses of covariance to assess the effect of gender on MBI-HSS subscale scores. Both studies reported a significant main effect for gender on the DP subscale, with women reporting lower levels of DP than men. Regression analysis also explored the interactions between gender, work setting and burnout (see below).

When comparing mean CBI scores, D'Souza et al. (2011) found females to have significantly higher personal burnout and work-related burnout but no significant gender differences were observed in client-related burnout mean scores. Considering quality assessment in relation to the sample within this study, it is notable that a small sample was used, with 86% of participants being female.

Work Setting, Gender and Burnout

The terminology used to describe work settings differed within the reviewed studies. Ackerley et al. (1988), Di Benedetto and Swadling (2014) and Emery et al. (2009), used the term 'private practice' to describe practitioners working independently, not within an organisation. In contrast Rupert and Kent (2007), Rupert and Morgan (2005) and Rupert et al. (2009) used the term 'solo independent practice' to describe such a work setting and the term 'group

independent practice' to describe practitioners working privately within a group organisation, for example as an affiliate, independent contractor or employee.

Rupert and Kent (2007) reported the EE subscale revealed a significant gender by work setting interaction. Main effect was qualified by a gender X work setting interaction. Women in agency settings reported significantly higher levels of EE than women in either solo independent or group independent practice. Additionally, women in group independent practice had the lowest levels of EE. However, these results did not differ significantly from those reported for women in solo independent practice. There were no significant differences observed in levels of EE for men across work settings. Additionally, no significant gender by work setting interactions were observed in the DP and PA subscales.

In line with Rupert and Kent's (2007) findings, Rupert and Morgan (2005) reported that women in agency settings reported significantly higher levels of EE than women in either solo independent or group independent practice. However, in contrast with Rupert and Kent's (2007) findings, men reported significantly higher levels of EE in group independent practice than men in agency settings or solo independent practice. In addition, men reported significantly greater EE than women in both solo independent and group independent practice, but women reported greater EE than men in agency settings. No work setting differences were seen in the DP subscale.

It is important to acknowledge the range of male to female representation within the studies investigating the associations and interactions between gender and burnout. Ackerley et al.'s (1988) study had a low percentage of female participants (27%), whereas Emery et al.'s

(2009) and D'Souza et al.'s (2011) studies had a low percentage of male participants (28.4% and 14% respectively). Rupert and Kent (2007), Rupert and Morgan (2005) and Rupert et al. (2009) samples consisted of an almost 50:50, male to female ratio of participants, indicating a more gender-equal sample than in the remaining studies.

Work Setting and Burnout

Ackerley et al. (1988) reported participants in private practice (solo independent practice) experienced lower EE, lower DP and higher PA than those in the public sector, while Emery et al. (2009) conducted regression analyses, reporting that working primarily in government settings was associated with higher levels of EE and higher levels of DP.

Rupert and Kent (2007), Rupert and Morgan (2005) and Rupert et al. (2009) reported the PA subscale yielded a main effect for work setting, with respondents in solo independent and group independent practice reporting higher levels of PA than those in agency settings. Additionally, Rupert and Morgan (2005) observed the EE subscale yielded a main effect for work setting, with solo independent practitioners reporting lowest levels and agency psychologists reporting the highest levels of EE. In contrast to other findings, Di Benedetto and Swadling (2014) found no significant differences in personal, work-related or client-related burnout between those working in private practice (solo independent practice) and those working in the public sector.

Discussion

This review focused on research assessing the prevalence of burnout and personal and occupational correlates of burnout amongst practitioner psychologists. The results of eight empirical studies, published between 1988 and 2017 were analysed. Overall, all studies demonstrated comparable, average methodological quality.

Prevalence of Burnout

It is unclear within the literature whether the concept of burnout should be classified as a psychiatric "disorder" or viewed more on a continuum. The early work of Freudenberger (1974) suggested that burnout is positioned as a disorder; either someone is 'burned out', or not. However, there are currently no binding diagnostic criteria and definitions are not uniform across the literature. Some researchers have used MBI-HSS cut-off scores proposed by Maslach and Jackson (1986) to assess rates or prevalence of burnout, with little clinical or diagnostic validity. Considering 80% of the studies included in the current review utilised the MBI-HSS to assess burnout, the overall prevalence of burnout among practitioner psychologists cannot be dependably determined.

The highest level of burnout, as indicated by mean scores on the MBI-HSS subscales, was observed in the sample of French professional psychologists (Berjot et al., 2017). However, whether considering the classification of burnout based on 'high', 'medium' or 'low' levels or solely on mean scores, there were no consistent findings of levels of burnout across the reviewed literature. Of the 80% of studies that utilised the MBI-HSS, a considerable range of

mean scores for each subscale was reported. All studies reported higher mean EE and PA scores than the mean scores for mental health workers proposed by Maslach et al. (2017).

When considering the prevalence of burnout determined by those studies which utilised the CBI (Kristensen et al., 2005), overall burnout was reported to have been present in 8 to 14.4% of participants. However, due to only two studies using this measure (Di Benedetto & Swadling, 2014; D'Souza et al., 2011), no generalisable conclusions can be drawn.

Burnout Correlates

Seven of the eight reviewed studies reported factors associated with burnout. Overall, low to moderate correlations were observed between burnout and some personal or occupational factors, with no strong associations observed. The majority of the associations between burnout and other factors were observed within the studies conducted in the USA.

The four studies conducted in the USA, reported consistent evidence of a low, negative association between the MBI-HSS EE subscale and age, and the DP subscale and age, indicating older participants report lower levels of EE and DP than their younger counterparts. A negative association between PA and age was also noted in two studies (Rupert & Kent, 2007; Rupert et al., 2009). D'Souza et al. (2011) also reported that each CBI subscale; personal burnout, work-related burnout and client-related burnout, was negatively associated with age. However, similar findings were not reported within a smaller sample of participants in Australia (Emery et al., 2009) and therefore conclusions cannot be drawn within the Australian population. Studies reporting an association between burnout and age support previous research suggesting stress

and burnout are more frequently observed in younger individuals in USA samples (Cushway & Tyler, 1994; Freudenberger, 1975, Martin-Johnson, 2016).

Additionally, two studies reported a negative association between years in service and overall burnout or associated subscales. Although studies did not provide information regarding the relationship between age and years of experience, it could be suggested these results further reinforce the relationship between age and burnout. Ackerley et al. (1988) proposed that a reduction in burnout with age and years in service may be down to therapists learning to conserve their emotional energy over time so as not to feel so exhausted or drained from the therapeutic process. More recently, Dorociak, Rupert and Zahniser (2017) explored the changes in wellbeing and self-care across the professional lifespan of psychologists. Findings suggest that 'late-career' psychologists engage in more self-care and 'early-career' psychologists report higher work-related demands and less professional resources.

Results from three studies conducted in the USA identified an association between working longer hours and higher levels of EE and DP. Barnett, Gareis, and Brennan (1999), previously examined the relationship between number of hours worked and burnout within a group of coupled physicians. Although an association was found, they proposed that work hours by themselves were not necessarily a direct cause of burnout. Instead, they suggested the relationship between work hours and burnout is mediated by an individual's preference for certain working hours and the relationship between the individual's and their spouse or partner's working hours. This highlights the role of individual difference factors which may contribute to the associations with burnout and the potential relevance of ascertaining an individual's perceptions and preferences related to such occupational factors.

There was inconsistent evidence detailing the association between gender and burnout. Methodological inconsistencies, most notably gender-imbalanced samples, mean no firm conclusions can be made. However, overall, associations were found between higher levels of EE, personal burnout, work-related burnout and being female. But higher levels of DP were associated with being male.

Five of the seven papers reported associations between work setting and burnout. Four studies were conducted in the USA and one in Australia. No associations between burnout, or associated subscales, and work setting was observed in the Australian study. However, of the four studies conducted in the USA, two studies reported that the highest levels of EE and DP were observed in those working in public/government settings and four studies reported those in private practice (both solo independent practice and group independent practice) reported higher levels of PA than those in agency settings or the public sector. Two studies also observed that the EE subscale revealed a significant gender by work setting interaction, with women in agency settings reporting significantly higher levels of EE than women in either solo independent or group independent practice. No additional work setting and gender interactions with burnout were consistently reported across these studies.

Overall, younger and less experienced individuals appear to be at increased risk of personal burnout, work-related burnout, client-related burnout, overall burnout, emotional exhaustion and depersonalisation of clients. Additionally, those working in public/government settings and those working longer hours also appear to be at increased risk of emotional exhaustion and depersonalisation of clients. However, those working in private practice (both solo independent practice and group independent practice) appear to demonstrate higher

levels of personal accomplishment, than those working in the public sector, government settings or agency settings.

Limitations

This review is restricted by its exclusion of non-English language papers and publication bias may exist as a consequence of the exclusion of unpublished grey literature. Furthermore, the review is limited by its exclusion of literature not currently indexed and searchable in electronic databases, for example, the British Psychological Society *Clinical Psychology Forum.* The use of a non-validated assessment tool could be deemed as a strength of this review, considering the tool was designed specifically to address methodological factors relevant to the reviewed studies. However, a weighted scoring system may have been most appropriate, giving priority to methodological aspects considered to be most important in identifying study quality.

Despite the identified associations, correlational studies cannot yield any statements regarding causation and identify only potential variables that are related to the experience of burnout within the studied population. The direction of influence can be determined only for fixed categoric variables but not for non-categoric variables and any associations found do not fully determine how these variables are related. It has been suggested that person-environment fit may play a role in the development of burnout (Leiter, Gascón & Martínez-Jarreta, 2010; Bakker, Demerouti, & Euwema, 2005). This implies that a complex set of person-related and work-related variables need to be considered and individual factors should not be seen as isolated predictors of burnout.

It is notable that there was a limited number of studies assessing burnout in practitioner psychologists internationally and no studies within the UK were identified through the searching methods used. Additionally, many of the reviewed studies exhibited significant methodological limitations. For example, 50% of the studies did not explain how missing data were managed and no studies explained whether the participant sample was representative of clinicians working within the profession or provided information regarding those who chose not to participate. Considering these limitations, and the use of different measures and methods of analysis, a meta-analysis could not be conducted, and no strong conclusions could be drawn.

It could be suggested that burnout research is biased towards healthy, working individuals. Those who are experiencing high levels of burnout, may not be working and therefore may not participate in such research. Therefore, results may provide little insight into the true nature of burnout within this population. Additionally, all studies used self-report data and no independent verification of the extent of burnout was given.

The MBI was originally developed by American researchers for use with American samples. As previously discussed, it is important to consider the role of culture and social context in how burnout is viewed. The findings of this review contradict the suggestion that EE and DP are higher in North American samples than in similar European samples (Schaufeli & Enzmann, 1998). However, it has been proposed that cross-national comparison of burnout should be conducted with caution (Schaufeli & Van Dierendonck, 1995). Health care in Australia and the USA is predominantly provided by private medical practitioners through health insurance. France, however, has an integrated network of public hospitals and private hospitals, with a universal service for every citizen, without a need for health insurance. Considering the

different characteristics of health care systems across the world, it could be suggested that differences in prevalence of burnout, and associations between organisational factors and burnout, would be expected cross-nationally.

Clinical Implications

As discussed, healthcare professional burnout has been found to have a significant impact at personal, patient and organisational levels. Considering this, both individual and organisational strategies should be employed to support practitioner psychologist wellbeing and avoid burnout. From an organisational perspective, an initial goal should be to appropriately monitor the professional wellbeing of psychological practitioners, in order to provide interventions at an individual level if necessary.

On an individual level, practitioner psychologists have an ethical responsibility to ensure they are fit to safely perform professional duties, as detailed within professional guidelines, for example, the Health Care Professionals Council (2015) Standards of Proficiency for practitioner psychologists and the National Law Act (2009).

Additionally, considering the finding that younger and less experienced individuals are at increased risk of dimensions associated with burnout, and Dorociak et al.'s (2017) suggestion that early-career psychologists experience lower levels of professional wellbeing relative to their more senior counterparts, specific support for younger practitioners may beneficial. Barnett and Cooper (2009), suggest that in order to promote practitioner wellbeing, the development of self-care strategies should begin as early as possible and should be particularly

encouraged during professional training. The importance of ongoing self-care as a core competency for practitioner psychologists has been proposed by Barnett and Cooper (2009) and Wise, Hersh and Gibson (2012). Practitioner psychologist training courses should promote a culture that prioritises practitioner wellbeing, through both organisational values and specific initiatives. For example, Norcorss and Guy, (2007) proposed that mentoring programmes could be an effective way to support younger practitioners and promote professional and personal wellbeing.

Future Research

The development of validated cut-off scores to identify differing levels of burnout would enable a clearer understanding of prevalence levels. Bianchi (2015) and Berjot et al. (2017) echoed this, proposing researchers should first agree on clinically valid criteria for assessing burnout and only following this, examine the prevalence within specific populations. Additionally, Berjot et al., (2017) propose burnout scores should be complemented with clinical interviews and subjective observations to assess whether an individual is experiencing burnout.

Furthermore, cross-sectional studies provide information at one given time. However, considering the proposed association between age and burnout and years in service and burnout, longitudinal studies should be conducted in future research to enable a more robust comparison between early-career practitioner psychologists and those with more experience by assessing the same individuals at different time intervals.

Conclusions

This review aimed to establish the prevalence and correlates of burnout in practitioner psychologists. Considering the difficulties with classification and measurement of burnout, the prevalence of burnout in practitioner psychologists cannot be generalised from the reviewed studies. However, the review demonstrates that overall, younger, less experienced practitioner psychologists, those working longer hours and those working in public/ government settings appear to be at increased risk of burnout and associated dimensions.

The current review highlights the necessity for robust, generalisable research to be conducted within this population in order to draw firm conclusions about prevalence and correlates of burnout amongst practitioner psychologists.

Conflict of Interest Declaration

References

Adriaenssens, J., De Gucht, V., & Maes, S. (2015). Determinants and prevalence of burnout in emergency nurses: A systematic review of 25 years of research. *International Journal of Nursing Studies*, *52*, 649-661. doi: 10.1016/j.ijnurstu.2014.11.004

Ackerley, G. D., Burnell, J., Holder, D. C., & Kurdek, L. A. (1988). Burnout among licensed psychologists. *Professional Psychology: Research and Practice*, *19*, 624-631. doi: 0735-7028/88

Bakker, A. B., Demerouti, E., & Euwema, M. C. (2005). Job resources buffer the impact of job demands on burnout. *Journal of occupational health psychology*, *10*, 170-180. doi: 10.1037/1076-8998.10.2.170

Barnett, J. E., & Cooper, N. (2009). Creating a culture of self-care. *Clinical Psychology: Science and Practice*, *16*, 16-20. doi: 10.1111/j.1468-2850.2009.01138.x

Barnett, R. C., Gareis, K. C., & Brennan, R. T. (1999). Fit as a mediator of the relationship between work hours and burnout. *Journal of Occupational Health Psychology, 4*, 307-317. doi: 1076-8998/99

Berjot, S., Altintas, E., Grebot, E., & Lesage, F. X. (2017). Burnout risk profiles among French psychologists. *Burnout Research*, *7*, 10-20. doi: 10.1016/j.burn.2017.10.001

Bianchi, R. (2015). A reflection on the measurement of the burnout syndrome. *Academic Emergency Medicine*, *22*, 378-378. doi: 10.1111/acem.12611

Bianchi, R., Schonfeld, I.S., & Laurent, E. (2014). Is burnout a depressive disorder? A

reexamination with special focus on atypical depression. *International Journal of Stress

Management*, *21*, 307-324. doi:10.1037/a0037906

Bianchi, R., Schonfeld, S. I., & Laurent, E. (2015). Burnout-depression overlap: A review. *Clinical

Psychology Review*, *36*, 28-41. doi: 10.1016/j.cpr.2015.01.004

Borritz, M., Rugulies, R., Bjorner, J. B., Villadsen, E., Mikkelsen, O. A., & Kristensen, T. S. (2006).

Burnout among employees in human service work: design and baseline findings of the

PUMA study. *Scandinavian journal of public health*, *34*(1), 49-58. doi:

10.1080/14034940510032275

Centre for Reviews and Dissemination. (2009). *Systematic reviews: CRD's guidance for

undertaking reviews in health care.* Retrieved from

https://www.york.ac.uk/media/crd/Systematic_Reviews.pdf

Cushway, D., & Tyler, P. A. (1994). Stress and coping in clinical psychologists. *Stress and

Health*, *10*, 35-42. doi.org/10.1002/smi.2460100107

Demerouti, E., Le Blanc, P.M., Bakker, A.B., Schaufeli, W.B., & Hox, J. (2009). Present but sick: A

three-wave study on job demands, presenteeism and burnout. *Career Development

International, 14*, 50-68. doi: 10.1108/13620430910933574

Dion, G., & Tessier, R. (1994). Validation de la traduction de l'Inventaire d'épuisement

professionnel de Maslach et Jackson [Validation of a French translation of the Maslach

Burnout Inventory (MBI)]. *Canadian Journal of Behavioural Science/Revue canadienne des Sciences du comportement, 26*, 210-227. doi: 10.1037/0008-400X.26.2.210

Dorociak, K. E., Rupert, P. A., & Zahniser, E. (2017). Work life, well-being, and self-care across the professional lifespan of psychologists. *Professional Psychology: Research and Practice*, *48*,   429-437. doi: 10.1037/pro0000160

D'Souza, F., Egan, S. J., & Rees, C. S. (2011). The relationship between perfectionism, stress and burnout in clinical psychologists. *Behaviour Change*, *28*, 17-28. doi: 10.1375/bech.28.1.17

Di Benedetto, M., & Swadling, M. (2014). Burnout in Australian psychologists: Correlations with work-setting, mindfulness and self-care behaviours. *Psychology, Health and Medicine*, *19*,   705-715. doi: 10.1080/13548506.2013.861602

Dyrbye, L. N., Thomas, M. R., Massie, F. S., Power, D. V., Eacker, A., Harper, W., … & Sloan, J. A. (2008). Burnout and suicidal ideation among US medical students. *Annals of Internal Medicine*, *149*, 334-341. doi: 10.7326/0003-4819-149-5-200809020-00008

Eelen, S., Bauwens, S., Baillon, C., Distelmans, W., Jacobs, E., & Verzelen, A. (2014). The prevalence of burnout among oncology professionals: oncologists are at risk of developing burnout. *Psycho-Oncology*, *23*, 1415-1422. doi: 10.1002/pon.3579

Emery, S., Wade, T. D., & McLean, S. (2009). Associations among therapist beliefs, personal resources and burnout in clinical psychologists. *Behaviour Change*, *26*, 83-96. doi: 10.1375/bech.26.2.83.

Fahrenkopf, A. M., Sectish, T. C., Barger, L. K., Sharek, P. J., Lewin, D., Chiang, V. W., ... &

Landrigan, C. P. (2008). Rates of medication errors among depressed and burnt out

residents: prospective cohort study. *British Medical Journal*, *336*, 488-491. doi:

10.1136/bmj.39469.763218.BE

Farber, B. A. (1983a). The effects of psychotherapeutic practice upon psychotherapists.

Psychotherapy: Theory, Research and Practice, *20*, 174-182. doi: 10.1037/h0088488

Farber, B. A. (1983b). Psychotherapists' perceptions of stressful patient behavior. *Professional

Psychology: Research and Practice*, *14*, 697-705. doi: 10.1037/0735-7028.14.5.697

Farber, B. A., & Heifetz, L. J. (1981). The satisfactions and stresses of psychotherapeutic work: A

factor analytic study. *Professional Psychology*, *12*, 621-630. doi: 10.1037/0735-

7028.12.5.621

Farber, B. A., & Heifetz, L. J. (1982). The process and dimensions of burnout in psychotherapists.

Professional Psychology, *13*, 293-301. doi: 10.1037/0735-7028.13.2.293

Field, A. (2018). *Discovering statistics using IBM SPSS Statistics* (5th ed.) London: Sage

Publications.

Freudenberger, H. J. (1974). Staff burn-out. *Journal of Social Issues, 30,* 159-65. doi:

10.1111/j.1540-4560.1974.tb00706.x

Freudenberger, H. J. (1975). The staff burn-out syndrome in alternative institutions.

Psychotherapy: Theory, Research and Practice, *12*, 73–82. doi: 10.1037/h0086411

Freudenberger, H.J. (1980). *Burnout: The high cost of high achievement*. Garden City, New York:

    Doubleday.

Greenhalgh, J., & Brown, T. (2014). Quality assessment: Where do I begin? In A. Boland, M. G.

    Cherry, R. & Dickson, (Eds.), *Doing a systematic review: A Students Guide* (pp. 61-83).

    London: SAGE Publications Ltd.

Gregory, S. T., & Menser, T. (2015). Burnout among primary care physicians: A test of the areas

    of worklife model. *Journal of Healthcare Management*, 60, 133-148. doi:

    10.1097/00115514-201503000-00009

Health Care Professionals Council. (2015). *Standards of Proficiency: Practitioner Psychologists.*

    London: Health Care Professionals Council.

Health Practitioner Regulation National Law Act 2009. Retrieved from

    https://www.legislation.qld.gov.au/view/html/inforce/current/act-2009-045

Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare staff wellbeing,

    burnout, and patient safety: a systematic review. *PLoS One*, *11*(7), 1-12. doi:

    10.1371/journal.pone.0159015

Johnson, J., Hall, L. H., Berzins, K., Baker, J., Melling, K., & Thompson, C. (2018). Mental

    healthcare staff well-being and burnout: A narrative review of trends, causes,

    implications, and recommendations for future interventions. *International Journal of*

    Mental Health Nursing, *27*, 20-32. doi: 10.1111/inm.12416

Kristensen, T.S., Borritz, M., Villadsen, E., & Christensen, K.B. (2005). The Copenhagen Burnout Inventory: A new tool for the assessment of burnout. *Work and Stress, 19,* 192–207. doi:10.1080/02678370500297720

Lambert, E. G., & Paoline, E. A. (2008). The influence of individual, job, and organizational characteristics on correctional staff job stress, job satisfaction, and organizational commitment. *Criminal Justice Review*, *33*, 541-564. doi: 10.1177/0734016808320694

Leiter, M. P., Gascón, S., & Martínez-Jarreta, B. (2010). Making sense of work life: A structural model of burnout. *Journal of Applied Social Psychology*, *40*, 57-75. doi: 10.1111/j.1559-1816.2009.00563.x

Leiter, M.P., & Maslach, C. (2009). Nurse turnover: The mediating role of burnout. *Journal of Nursing Management, 17*, 331–339. doi: 10.1111/j.1365-2834.2009.01004.x

Martin-Johnson, K. (2016). *Gender and self-care behaviors in the burnout of mental health professionals*. (Doctoral thesis). Retrieved from Scholar Works.

Maslach, C. (1976). Burned-out. *Human Behavior, 5,* 16-22.

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior*, *2*, 99-113. doi: 10.1002/job.4030020205

Maslach, C., & Jackson, S.E. (1986). *Maslach burnout inventory manual* (2nd ed.). Palo Alto, California: Consulting Psychologists Press.

Maslach, C., Jackson, S.E., & Leiter, M.P. (1996). *Maslach Burnout Inventory manual* (3rd ed.). Palo Alto: Consulting Psychologists Press.

Maslach, C., Jackson, S. E., & Leiter, M. P. (2017) *Maslach burnout inventory manual*. (4th ed.)

USA: Mind Garden, Inc.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of*

Psychology, *52*, 397-422. doi: 10.1146/annurev.psych.52.1.397

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for

systematic reviews and meta-analyses: the PRISMA statement. *International journal of*

surgery, *8*(5), 336-341. doi: 10.1371/journal.pmed.1000097

Norcross, J. C., & Guy, J. D. (2007). *Leaving it at the office: A guide to psychotherapist self-care*.

New York: Guilford Press.

Özkan, S., Karaman, E. U., Öztürk, N., Ahun, F. A., & Selmi, N. H. (2015). The relationship of

burnout with job satisfaction and suicide ideation among anesthesiologists. *Journal of*

Clinical and Experimental Investigations, *6*, 175-182. doi:

10.5799/ahinjs.01.2015.02.0512

Petticrew, M., & Roberts, H. (2008). *Systematic reviews in the social sciences: A practical guide*.

Oxford, UK: Backwell Publishing.

Rothenberger, D. A. (2017). Physician burnout and well-being: a systematic review and

framework for action. *Diseases of the Colon & Rectum*, *60*(6), 567-576. doi:

10.1097/DCR.0000000000000844

Ruotsalainen J.H., Verbeek J.H., Mariné A., & Serra C. (2015). Preventing occupational stress in

healthcare workers. *Cochrane Database of Systematic Reviews* (4). doi:

10.1002/14651858.CD002892.pub5

Rupert, P. A., & Kent, J. S. (2007). Gender and work setting differences in career-sustaining

behaviors and burnout among professional psychologists. *Professional Psychology:*

Research and Practice, *38*, 88-96. doi: 10.1037/0735-7028.38.1.88

Rupert, P. A., & Morgan, D. J. (2005). Work setting and burnout among professional

psychologists. *Professional Psychology: Research and Practice*, *36*, 544–550. doi:

10.1037/0735-7028.36.5.544

Rupert, P. A., Stevanovic, P., & Hunley, H. A. (2009). Work-family conflict and burnout among

practicing psychologists. *Professional Psychology: Research and Practice*, *40*, 54-61. doi:

10.1037/a0012538

Schaufeli, W., & Enzmann, D. (1998). *The burnout companion to study and practice: A critical*

analysis. Philadelphia: Taylor & Francis.

Schaufeli, W. B., Leiter, M. P., & Maslach, C. (2009). Burnout: 35 years of research and

practice. *Career development international*, *14*(3), 204-220. doi:

10.1108/13620430910966406

Schaufeli, W. B., & Van Dierendonck, D. (1995). A cautionary note about the cross-national and

clinical validity of cut-off points for the Maslach Burnout Inventory. *Psychological*

reports, *76*, 1083-1090. doi: 10.2466/pr0.1995.76.3c.1083

The Joanna Briggs Institute. (2016). *The Joanna Briggs Institute critical appraisal tools for use in JBI systematic reviews: Checklist for prevalence studies*. Retrieved from http://joannabriggs.org/research/critical-appraisal-tools.html

The Joanna Briggs Institute. (2017). *Joanna Briggs Institute Reviewer's Manual*. Retrieved from https://reviewersmanual.joannabriggs.org/

Vahey D.C., Aiken L.H., Sloane D.M., Clarke S.P., & Vargas D. (2004). Nurse burnout and patient satisfaction. *Medical Care*, *42,* 57-66. doi: 10.1097/01.mlr.0000109126.50398.5a

van Mol, M. M., Kompanje, E. J., Benoit, D. D., Bakker, J., & Nijkamp, M. D. (2015). The prevalence of compassion fatigue and burnout among healthcare professionals in intensive care units: a systematic review. *PloS One*, *10*(8), 1-22. doi: 10.1371/journal.pone.0136955

Williams, E.S., Manwell, L.B., Konrad, T.R., & Linzer, M. (2007). The relationship of organizational culture, stress, satisfaction, and burnout with physician-reported error and suboptimal patient care: Results from the MEMO study. Health Care Management Review, 32, 203-212. doi: 10.1097/01.HMR.0000281626.28363.59

Wise, E. H., Hersh, M. A., & Gibson, C. M. (2012). Ethics, self-care and well-being for psychologists: Reenvisioning the stress-distress continuum. *Professional Psychology: Research and Practice*, *43*(5), 487. doi: 10.1037/a0029446

Paper 2 has been prepared in accordance with the author guidelines for submission to the Journal of Occupational and Organizational Psychology (Appendix D), with the exception of the inclusion of tables within the main text.

Paper 2: The Development of a New Measure to Assess the Workplace Wellbeing of Psychological Practitioners

Word count (exc. figures/tables): 7905

Abstract

This paper reports the development and validation of a new measure, the Psychological

Practitioner Workplace Wellbeing Measure (PPWWM). The 26-item measure contains items

which reflect a broad range of issues relevant to the unique aspects of workplace wellbeing of

psychological practitioners.

The PPWWM was shown to have favourable psychometric properties, including high internal

consistency (α = .92) and high test-retest reliability (r = . 94, p < .001). Additionally, scores on

the PPWWM correlate highly with other measures designed to assess work-related stressors,

satisfaction with life and general health, indicating high construct validity. An exploratory factor

analysis produced a set of six factors, explaining 61.2% of the variance within the measure:

professional and organisational; support and flexibility; professional role; physical environment;

clinical supervision; external personal. It is noted that PPWWM scores were not significantly

associated with a range of demographic variables, (gender, health/disability, profession, type of

organisation or contract), but it did correlate significantly and negatively with age.

Keywords: Wellbeing, measure, assessment, psychological practitioner, practitioner

psychologist, health professional

Introduction

Healthcare Professional Wellbeing

The importance of employee wellbeing is increasingly recognised in many professional circles. In the United Kingdom (UK), there is a particular growing interest in the wellbeing of healthcare professionals. This has been both stimulated and maintained by national reports (Boorman, 2009), guidelines (The National Institute for Health and Clinical Excellence (NICE), 2009; Stevens, 2014) and an increasing evidence base detailing the strong links between employee wellbeing, organisational performance and patient outcomes.

Being in employment has been linked to positive life outcomes and overall wellbeing (Chmiel, Brunner, Martin & Schalke, 2012; Glasper, 2010). However, employment is not universally beneficial and can also have detrimental effects on an individual's wellbeing. The potential negative impacts have been largely documented in the form of occupational stress. The Health and Safety Executive (HSE, 2004a) proposed occupational stress occurs when an individual perceives the demands and pressure of their role outweigh their ability to cope. There is evidence to suggest that occupational stress is more likely in certain professions, for example, those in healthcare professions (Johnson et al., 2005).

It is important to note however, that the concept of workplace wellbeing is not simply associated with occupational stress or conversely the absence of negative symptoms (Schulte & Vainio, 2010). NICE (2009, p. 8) propose workplace wellbeing is "determined by the interaction between the working environment, the nature of the work and the individual". O'Donnell et al.

(2014) highlighted four factors associated with high levels of workplace wellbeing: (1)

employees have a clear idea of what is expected of them and how they relate to the wider

team and organisation; (2) employees have reasonable freedom, autonomy and control over

how they do their work; (3) employees have support, recognition and reward for their work; (4)

employees have a reasonable work/life balance.

There is an abundance of research detailing the strong links between healthcare

professional wellbeing and the delivery of dignified and safe patient care. For example, the UK

National Health Service (NHS) Health and Wellbeing Review (Boorman, 2009), commissioned by

the UK Department of Health (DoH) identified distinct associations between employee health

and wellbeing and three dimensions of service quality: patient safety, patient experience and

the effectiveness of patient care. Boorman (2009) highlighted that organisations prioritising

staff wellbeing show improved patient satisfaction, improved staff retention, lower rates of

sickness absence and burnout and improved patient outcomes. These findings are also

evidenced extensively within research literature. For example, there is significant research

detailing the link between physician stress, burnout and general psychological distress and the

provision of a reduced quality of patient care (Firth-Cozens, 2001; Gunderson, 2001; Shanafelt,

Bradley, Wipf & Back, 2002).

Psychological Practitioner Wellbeing

The term 'psychological practitioner' used within this study, includes any professionally qualified practitioner working in a psychological/psychotherapeutic role.

The professional and personal demands of psychotherapeutic work have been documented for many years (Farber, 1983; Farber & Heifetz, 1981). Psychological practitioners are often exposed to significant distress within their role and also frequently face systemic pressures, such as limited resources and excessive demands (Rupert & Morgan, 2005). There is strong evidence detailing occupational hazards among this professional group (Norcross & Guy, 2007; Wise, Hersh & Gibson, 2012). For example, Smith and Burton Moss (2009) proposed risk factors associated with an impairment in the functioning of psychologists included managing the intimate, confidential and non-reciprocal nature of the therapeutic relationship, isolation (particularly for those in private practice), patient risk management and a low control and high demand work context. As a consequence of the challenges faced, potential personal risks within the profession include anxiety, depression, occupational stress, vicarious traumatisation, burnout and compassion fatigue (Cushway & Tyler, 1994; Di Benedetto, 2015; Dattilio, 2015; Smith & Burton Moss, 2009).

Particular concerns have been raised about psychological practitioner wellbeing in England following the introduction of the Improving Access to Psychological Therapies (IAPT) programme. IAPT began in 2008 and was initially introduced with the aim of making evidence-based interventions for adults with depression and anxiety more accessible. IAPT services have a target driven culture, with an expectation of high volumes of client contacts, as many as 45

active cases at one time for psychological wellbeing practitioners (DoH, 2009), and many IAPT

employees are relatively young and inexperienced clinicians (Rizq, 2009). High targets and

caseloads, low control over work, younger age and less years of experience are all factors that

have been associated with an increased risk of psychological practitioner burnout (Di Benedetto

& Swadling, 2014; D'Souza, Egan & Rees, 2011; Lasalvia, et al., 2009; Rupert & Kent, 2007).

Steel, MacDonald, Schröder and Mellor-Clark (2015) investigated burnout in a sample of 116

IAPT therapists, utilising the Maslach Burnout Inventory (Maslach, Jackson & Leiter, 1996),

identifying high levels of emotional exhaustion within this sample, with emotional exhaustion

being predicted by high work demands and lack of autonomy.

Following the national roll-out of IAPT services in England, in 2009 the New Savoy

Partnership (NSP) surveyed the wellbeing of psychological therapies staff and managers in the

NHS, using a measure based on the European Social Survey (New Economics Foundation, 2009).

Following this, in 2014, a joint initiative between the NSP and the British Psychological Society

(BPS) Division of Clinical Psychology (DCP) Leadership and Management Faculty was

established. Core objectives of the NSP and DCP collaboration included conducting an annual

measure of workforce wellbeing in psychological services, developing a charter for

psychological wellbeing, developing a strategic framework and wellbeing tool, and establishing

a 'Collaborative Learning Network' to share good practice and drive the wellbeing agenda.

In 2014, the NSP and DCP collaborative group disseminated their first national

workforce wellbeing survey for psychological practitioners to assess general and workplace

wellbeing. In 2015 and 2016, they further developed the measure, to include some items from

the Work-Related Quality of Life scale (WRQoL) (Van Laar, Edwards, & Easton, 2007). Of the

1227 respondents in 2016, 48% of psychological practitioners indicated they had felt depressed

'some of the time' or more frequently over the previous week, 46% indicated they had felt like

a failure 'some of the time' or more frequently over the previous week and 92% indicated they

found their job stressful 'some of the time' or more frequently (Dosanjh & Bhutani, 2017).

Despite these concerning results, it is notable that the measures used to assess workplace

wellbeing were not scientifically validated.

Assessment of Workplace Wellbeing

Considering the evidence base detailing the association between healthcare

professional wellbeing and patient care and the impact of low levels of workplace wellbeing on

individuals and the wider organisation, it is essential that the wellbeing of psychological

practitioners is monitored and assessed, as recommended by NICE guidelines (2009). To

ascertain levels of wellbeing, clarity around methods of assessment is essential. However, there

is widespread variation in organisational measurement of employee wellbeing, with the

majority of research utilising measures of general wellbeing, job satisfaction, stress, negative

effect, burnout or quality of working life (Dimotakis, Scott & Koopman, 2011).

A recent review (Linton, Dieppe & Medina-Lara, 2016) identified 99 self-report

measures which claim to assess general wellbeing in adults. This highlighted the range of

different dimensions that are included under the umbrella of wellbeing assessment. Some

specific work-related measures have also been developed, including measures to assess stress at work (HSE, 2004b) and measures to assess 'quality of work life' in business and commercial settings (Eaton, Mohr, Hodgson & McPhaul, 2018), and healthcare settings (Van Laar, et al., 2007). However, none of these measures sufficiently addresses the unique work-related factors (Cushway, & Tyler, 1994; Farber, & Heifetz, 1981) associated with the role of a psychological practitioner.

Aims

There are currently no validated tools to specifically measure the subjective workplace wellbeing of psychological practitioners. This study aimed to develop and validate a new measure: The Psychological Practitioner Workplace Wellbeing Measure (PPWWM). This will enable the effective assessment of workplace wellbeing, which in turn may lead to appropriate action being taken to support psychological practitioners and to ensure the best care is provided to people who access psychological services.

Hypotheses

It was hypothesised that the PPWWM would show high construct validity as indicated by correlations with relevant scales:

a) A positive correlation between the Health and Safety Executive Management Standards Indicator Tool (HSEMS-IT) (HSE, 2004b) and PPWWM

b) A positive correlation between Satisfaction with Life Scale (SWLS) score (Diener,

   Emmons, Larsen & Griffin, 1985) and PPWWM score

c) A negative correlation between General Health Questionnaire (GHQ-12) score

   (Goldberg, 1992) and PPWWM score

It was also hypothesised that the PPWWM would show high internal consistency as

indexed by Cronbach's α and item analysis statistics and the PPWWM would show high test-

retest stability as indicated by the correlation between tests at Time 1 and Time 2, 7 to 14 days

apart.

Exploratory factor analysis was conducted to determine the latent factors contained in

the PPWWM. It was hypothesised that common factors with an eigenvalue greater than 1.0

would be identified (Kaiser, 1960, cited in Field, 2018).

Method

Ethical Considerations

This study was approved by the Cardiff University ethics committee (Appendix E). All participants provided consent to participate at each stage of the survey development.

Data Collection and Storage

Data collection was conducted using the web-based survey software Qualtrics, with password protected access. No identifiable information was obtained, with the exception of email addresses from participants wishing to provide these for further participation. Email addresses were deleted once the participant had completed their involvement in the study. All anonymised data will be stored for 15 years, as per university research protocol.

Phase 1 – Qualitative Interviews

The development of the measure was conducted in two independent phases. Phase 1 (McLellan, in submission) aimed to qualitatively identify constructs of psychological practitioner general wellbeing. Fifteen, UK based, psychological practitioners participated in semi-structured interviews. The transcripts were analysed using thematic analysis, identifying 14 salient

constructs, categorised into four key areas, relating to psychological practitioner wellbeing. Full details of Phase 1 may be found in McLellan (in submission).

Phase 2 – Measure Development

The measure development process was informed by the work of DeVellis (2017) and consisted of 5 initial stages, followed by the psychometric evaluation of the new measure. Participants were recruited via professional acquaintances of the researcher and professional networks, including the BPS, DCP and its subsystems, and the Psychological Professions Network (PPN) North West (see Appendix F and Appendix G for letters off approval for dissemination). At each stage of the measure development, individuals were invited to participate if they were currently employed within an organisation (e.g. NHS, independent sector, third sector), as a qualified psychological practitioner (including clinical psychologist, counselling psychologist, health psychologist, forensic psychologist, high intensity therapist, cognitive behaviour therapist, psychological wellbeing practitioner, counsellor, arts therapist, psychoanalyst, psychotherapist, family therapist). Individuals working solely in private practice, or those who were not professionally qualified, were not eligible to participate. All participants were required to provide consent to participate at each stage of the measure development and validation.

Procedure

Stage 1: Item Development

The researcher created an initial pool of 87 items reflecting the broad conceptualisation of psychological practitioner workplace wellbeing. Items were phrased as declarative statements with the aim of producing clear and concise items that would elicit unambiguous responses relating to each individual construct.

Items were developed based on workplace wellbeing and quality of working life literature (e.g. NICE, 2009; O'Donnell et al., 2014; Stevens, 2014), previously validated measures (e.g. Work-Related Quality of Life Scale; Van Laar, Edwards, & Easton, 2007) and the 14 psychological practitioner wellbeing constructs identified in Phase 1 (McLellan, in submission) shown in Table 1. Phase 1 identified one construct relating to personal wellbeing: 'personal support from family and friends'. Following a review of the qualitative interview quotes related to this construct, it was decided to retain this construct within the measure development considering the overlap with workplace factors and the work and personal life interface.

Table 1

Phase 1 Psychological Practitioner Wellbeing Constructs

	Domains	Constructs
1.	Personal support	Friends and family
		Colleagues
		Clinical supervision
		Professional management
2.	Organisational context	Targets
		Hopefulness/ hopelessness
		Pressure
3.	Positive and negative job aspects	Control and autonomy over work
		Feeling valued
		Opportunities to learn
		Physical environment
		Work/Life balance
4.	Inter-professional agents	Line-management
		Role clarity

Stage 2: Item Review

Psychological practitioners known to the researcher, with a special interest in workplace wellbeing, were invited to participate in the item review (12 clinical psychologists and one cognitive behaviour therapist). Individuals were contacted via email with information regarding the overall aim of the study and an invitation to participate in a focus group to review the initial pool of items. A focus group was conducted with five clinical psychologists (38.5% response

rate). All participants were employed within the NHS, in adult mental health (n= 1), clinical

health (n=3) and learning disability (n=1) settings.

Due to small number of participants in the focus group, a further review of items was

completed via a web-based Qualtrics survey. Participants were recruited via researcher

professional acquaintances. Individuals who were unable to attend the focus group (n=8) and

two members of the Leadership and Management Faculty of the BPS, DCP were contacted via

email, with an invitation to participate in the survey, seeking qualitative feedback on the initial

pool of items. Contacted individuals were asked to share the survey within their professional

networks. Four clinical psychologists completed the survey. Participants were employed in the

independent sector (n=2) and NHS (n=2), in older adult (n=2), forensic (n=1) and adult mental

health (n=1) settings, which improved the representation of professionals from a range of

occupational settings.

In both the focus group and survey, participants reviewed the pool of 87 items,

evaluating the relevance of items to their construct, clarity, wording and ambiguity. Items were

added, adapted or removed based on group consensus. Negatively and positively keyed items

were included to reduce acquiescence response bias (approximately 70% positively worded).

Participants deemed there was the need for an additional construct, and related items:

'organisational engagement'. This construct was concerned with a sense of inclusion in, and

belonging to, the organisation and agreement with organisational objectives. It was felt that

these factors had not been sufficiently addressed within the initially proposed constructs and

associated items. The pool of items was refined to contain 60 items: four items relating to each

of the identified 15 constructs of psychological practitioner workplace wellbeing (see Appendix H).

Stage 3: Construct Review

A 60-item web-based Qualtrics survey was distributed to professional networks and mailing lists to cross-check items with the constructs of psychological practitioner workplace wellbeing. Individuals were contacted via email with information regarding the overall aim of the study, with an invitation to participate in this stage of the measure development and a request to share the invitation to participate within their professional networks. Item order was randomised, and participants were required to select a single construct, from the list of 15 constructs, which they deemed most corresponded with each presented item (4 items per construct: total of 60 items).

It is unknown how many psychological practitioners received the invitation to participate in this survey. Twenty-six participants completed the survey: clinical psychologist (n=20); counselling psychologist (n=1); high intensity therapist (n=4); arts therapist (n=1). Psychological practitioners were employed in a range of occupational settings; clinical health (n=4); adult mental health (n=7); learning disabilities (n=8); neuropsychology (n=1); older adult (n=2); children and adolescents (n=2); organisational/management (n=2).

Results enabled the identification of the number of times each construct was selected as corresponding with each of the 60 presented items (see Appendix I). Each item was reviewed to

82

assess whether the construct which it had been intended to represent had most frequently been chosen by participants. Fifty-six of the 60 items were most frequently matched with the intended construct.

Results indicated that the four items intended to correspond with the 'professional line-management' construct, were most frequently selected to correspond with the 'line-management support' construct. Therefore, these four items were reviewed alongside the items intended to correspond with the 'line-management support' construct. Of these eight items, the four items with the highest frequency agreement with the 'line-management support' construct were selected for inclusion, removing the remaining four items. Additionally, the four items associated with the 'pressure' construct were deemed to correspond with a range of different constructs, with the 'pressure' construct being selected by ≤ 50% of the participants for each of the four items. Because of a lack of agreement, these items were removed.

Fifty-two items, relating to 13 constructs of psychological practitioner workplace wellbeing, were retained (four items per construct). Constructs: friends and family support; colleague support; clinical supervision support; line-management support; organisational targets; organisational hopefulness; organisational engagement; work control and autonomy; feeling valued; opportunities to learn; physical environment and facilities; work/life balance (see Appendix J).

Stage 4: Ranking of Item Relevance for Inclusion

A web-based Qualtrics survey was created containing a non-randomised list of each psychological practitioner workplace wellbeing construct and the four associated items (see Appendix J). This stage required participants to rank the four items associated with each of the 13 constructs in order of importance/ relevance/ appropriateness for inclusion in the final measure, from 1: most important/ relevant/ appropriate for inclusion to 4: least important.

Members of professional networks, including the PPN North West, were contacted with information regarding the overall aim of the study and an invitation to participate in this stage of the measure development. Again, participants were requested to share the invitation to participate within their professional networks as appropriate. It is unknown how many individuals received the invitation to participate.

Thirty-nine participants completed the survey: clinical psychologist (n=21); counselling psychologist (n=4); high intensity therapist (n=8); counsellor (n=3); and psychological wellbeing practitioner (n=3). Psychological practitioners were employed in a range of occupational settings; adult mental health (n=18); children and adolescents (n=7); older adults (n=6); learning disability (n=6); and forensic (n=2).

For each of the 13 constructs, the four related items received an overall score based on participants' selection of importance (see Appendix K). Lower overall scores indicated items being selected for inclusion more frequently. The sum of individual scores for each item and descriptive statistics were reviewed. The two items which were deemed to be of most

importance/ relevant/ appropriate for inclusion were retained (lowest sum score) and the remaining two items were removed (see Appendix L).

Stage 5: Measure Review

The order of items was randomised and a draft PPWWM survey was developed (see Appendix M). Eight individuals with a special interest in psychological practitioner workplace wellbeing (professional acquaintances of the researcher and individuals from the DCP Leadership and Management Faculty) were contacted and asked to review the wording of statements and time taken to complete the survey. Five individuals participated in this review process and no changes to the PPWWM were proposed. The PPWWM was thought to take approximately five minutes to complete.

Finalisation of the Measure

The final measure (see Appendix M), contains 26 items, based on 13 constructs of psychological practitioner workplace wellbeing: 2 items per construct. The measure contains 21 positively keyed and 5 negatively keyed items. Likert scaling is widely used when measuring subjective opinions and was therefore deemed appropriate for this measure. The PPWWM contains a 5-point Likert scale for scoring ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), with a minimum possible score of 26 and a maximum score of 130. Following reverse

scoring for negatively keyed items, low scores indicate poor workplace wellbeing, while high scores indicate high workplace wellbeing.

Main Study: Psychometric Analysis of the PPWWM

Sample Size

There is no single established convention for determining sample size for the development of questionnaire evaluation measures. However, some hypotheses utilised correlations. Therefore, the assessment of statistical power was conducted using G*Power software (Faul, Erdfelder, Lang & Buchner, 2007) to determine the required sample size for the correlations. Using an alpha of .05, G*Power estimated a minimum sample size of 153 participants to detect a small correlation of .2, at a power of .8 (an 80% chance of detecting a correlation).

When conducting a factor analysis, Tinsley and Tinsley (1987) propose a ratio of 5 to 10 participants per item. Therefore, considering the PPWWM is a 26-item measure, 130-260 participants would suffice.

Participant Inclusion and Exclusion Criteria

As with earlier stages of survey development, participants met the inclusion criteria if, at time of completion of the survey, they were employed in the UK, within an organisation (e.g. the NHS, independent sector or third sector) and were a qualified psychological practitioner. Participants were excluded if they solely worked in private practice or were unqualified professionals, due to different organisational and professional demands associated with these populations. Participants were required to be able to communicate in English.

Measures

A web-based Qualtrics survey was created (Appendix N) and included the 26-item PPWWM, an 11-item demographic survey, the HSEMS-IT (HSE, 2004b), Satisfaction with Life Scale (SWLS) (Diener et al., 1985) and the 12 item General Health Questionnaire (GHQ-12) (Goldberg, 1992).

To assess the temporal stability (reliability) of the PPWWM, at Time 1 participants were given the opportunity to provide their email address if they were willing to be contacted to recomplete the survey at Time 2. Participants who opted to be contacted (n=279), were sent the PPWWM seven days after first completion and were required to complete the Time 2 survey within one week of receipt. Therefore, Time 2 was 7 - 14 days after Time 1.

Demographic Survey

The demographic questionnaire collected the participant's profession, type of contract, years since professional qualification, years worked since professional qualification, years employed in current post, contracted hours, type of employer organisation, pay scale, gender, illness and disability and age.

Health and Safety Executive Management Standards Indicator Tool (HSE, 2004b)

The UK Health and Safety Executive developed Management Standards (HSEMS) for organisations which highlight six discrete but related areas of work design, which if not appropriately managed, are associated with poor employee health and work-related stress: demands, control, support, relationships, role, and change (for HSEMS development see Cousins et al., 2004). Alongside the HSEMS, a self-report measure was developed, the HSEMS-IT (HSE, 2004b). This 35-item measure relates to the six key areas of work design/ work-related stressors identified in the HSEMS. An exploratory factor analysis approach was used to extract factors best representing the HSEMS, indicating seven factors/subscales within the measure: demands; control; managerial support; peer support; relationships; role; and change (Cousins et al., 2004). These factors have more recently been confirmed by Edwards, Webster, Van Laar and Easton (2008) by conducting first-order confirmatory factor analysis using a large sample of 26,382 employees from 39 organisations in the UK, including 15 NHS Trusts or hospitals.

The 'demands' factor includes items concerned with workload, work patterns and work environment. 'Control' refers to how much say an individual has over the way they do their work. 'Peer support' includes items associated with the encouragement, sponsorship and resources provided by colleagues and 'managerial support' is similar but concerned with the support provided by the organisation and line-management. The 'relationships' factor relates to promoting positive working to avoid conflict in the workplace and dealing with unacceptable behaviour, for example workplace bullying. The 'role' factor is concerned with whether individuals understand their role and responsibilities within the organisation and whether the organisation ensures they do not have conflicting roles. 'Change' includes items relating to how organisational change is managed and communicated to individuals within the organisation.

The measure was designed as an accessible resource for organisations and employers, to investigate employees' exposure to work-related stress dimensions. Participants are required to indicate the frequency of agreement with each item on a Likert scale ranging from 1 (*never*) to 7 (*always*). Scores range from 35 to 175 where low scores indicate higher levels of work-related stressors. To facilitate analysis, survey responses can be compiled into an Excel-based Analysis Tool (HSE, n.d.) which provides an overall score and separate scores for the seven work-related stressor subscales.

The overall Cronbach's α reliability for the HSEMS-IT has been found to be .92 (Edwards, Webster, Van Laar & Easton (2008), which indicates high internal consistency (DeVellis, 2017). The reliability of each of the seven work-related stressor subscales have also been investigated by Cousins et al. (2004) and Edwards et al. (2008) and can be found in Table 2. To the author's knowledge, the test-retest reliability of the HSEMS-IT has not been evaluated. However, the

HSEMS-IT has been used in a range of professional settings and has demonstrated good

construct validity. HSEMS-IT scores have been found to be positively associated with job

satisfaction and negatively associated with job-related anxiety and depression in a UK health

and social services trust (Kerr, McHugh & McCory, 2009).

Table 2

HSE Management Standards Indicator Tool Subscale Reliability

Work-related stressor subscale	Cousins et al., (2004) α	Edwards et al., (2008) α
Demands	.89	.87
Control	.78	.82
Managerial support	.87	.88
Peer support	.81	.82
Relationships	.78	.78
Role	.83	.83
Change	.83	.80

Satisfaction with Life Scale (Diener et al., 1985)

The SWLS is a five-item self-report measure, designed to broadly assess an individual's

global evaluative judgement of their life satisfaction according to their own criteria. Participants

are required to indicate how much they agree or disagree with each of the five statements

using a seven-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The

measure provides an overall satisfaction with life score ranging from five to 35. Scores are

differentiated as, 31–35, extremely satisfied; 26–30, satisfied; 21–25, slightly satisfied; 20, neutral; 15–19, slightly dissatisfied; 10–14, dissatisfied; and 5–9, extremely dissatisfied.

The SWLS has been used in a wide range of studies (Pavot & Diener, 2008) including those in healthcare settings (Oates, Jones & Drey, 2017) and shows high internal consistency with Cronbach's α coefficient reported to be .85 (Pavot, Diener, Colvin & Sandvik, 1991) and .87 (Diener et al., 1985). Temporal stability has also been investigated, with the two-month test-retest correlation coefficient reported as .82 (Diener et al., 1985) and one-month test-retest correlation coefficient of .84 (Pavot et al., 1991). Furthermore, the SWLS has been found to have a single factor solution (Diener et al., 1985) and has demonstrated good construct validity (Pavot & Diener, 2008) with convergent and discriminant measures. For example, strong negative associations have been observed between SWLS score and depression and SWLS score and negative affect (Larsen, Diener & Emmons, 1985).

General Health Questionnaire (Goldberg, 1992)

The GHQ-12 is a self-report, 12-item scale. This shortened version of the original 60-item GHQ (Goldberg, 1978), is designed to detect non-psychotic mental health and is commonly used worldwide (Werneke, Goldberg, Yalcin & Ustun, 2000). It has been validated to assess psychological morbidity for use in clinical and non-clinical populations (e.g. Ruiz, García-Beltrán & Suárez-Falcón, 2017) and within healthcare professional samples in the United Kingdom, NHS (Hardy, Shapiro, Haynes & Rick, 1999). The scale assesses whether the respondent has

experienced a particular symptom or behaviour over the 'last few weeks', using a four-point

scale: less than usual, no more than usual, rather more than usual, or much more than usual.

Two scoring methods are available for this test: bimodal, where all items are scored as 0

or 1 and total scores range from 0 to 12, or the four-point Likert scale, where all items are

scored from 0 to 3 and total scores range from 0 to 36. Higher scores indicate poorer mental

health, regardless of scoring method. The four-point Likert scale method was utilised within this

research because a statistically more acceptable distribution is created with this method (Hardy

et al., 1999).

The internal consistency of the GHQ-12, using Cronbach's α coefficient, has been

reported to be .90 (Hankins, 2008). Test-retest reliability values, using Likert scoring, have been

reported to be .72 (Picardi, Abeni & Paquini, 2001) and .82 (Piccinelli, Bisoffi, Bon, Cunico &

Tansella, 1993). Furthermore, the GHQ-12 has demonstrated good construct validity. For

example, a negative association has been observed between high GHQ-12 scores and good

overall wellbeing (Fat, Scholes, Boniface, Mindell & Stewart-Brown, 2017) and a positive

association observed between high GHQ-12 scores and depression (Ludin, Hallgren, Theobald,

Hellgren & Torgen, 2016).

Statistical Analysis

Data analysis was conducted via the statistical software IBM SPSS® version 23. Prior to

analysis, the normality of the data was examined by investigating skewness, kurtosis and by

conducting a Kolmogorov-Smirnov test, to determine whether the assumptions for parametric

testing were met. To establish their significance, skewness and kurtosis scores were converted to z-scores by dividing the estimates of skew and kurtosis by their standard errors.

To assess the construct validity of the PPWWM, the associations between PPWWM scores and the three additional measures (HSEMS-IT, SWLS and GHQ-12) were conducted. Pearson's correlations, using the bootstrapping module in SPSS, were conducted due to non-normal distribution of data. The internal consistency of the PPWWM was assessed using Cronbach's α and the temporal stability was assessed using a Pearson's correlation with bootstrapping and a repeated analysis of variance (ANOVA).

Exploratory factor analysis was used to determine the latent constructs contained in the 26-item PPWWM. Initially, the factorability of the 26 PPWWM items was examined. The Bartlett's Sphericity Test and the Kaiser-Meter-Olkin (KMO) measure of sampling adequacy and an inspection of the correlation matrix were performed to determine whether the data could be factored.

Results

Descriptive Data

In total, 479 responses were obtained. The survey required participants to answer all questions with a forced-response setting. Sixty-seven incomplete responses were removed. A further 10 responses were removed as a result of participants not meeting the inclusion criteria and two responses were removed due to providing over 90% of the same responses to all items. The final sample included 400 responses. The achieved power with this sample size, to detect a small correlation of .2 with α set at .05, was .99. Similarly, to detect a very small correlation of .1, the achieved power was .64 (Faul et al., 2007).

Of the 279 participants that were contacted 7 days after first completion of the PPWWM, 194 participants (70%) completed the survey at Time 2 within one week of receiving the email request (7 - 14 days after first completion). With the exception of the temporal stability analysis, data analysis was conducted with the results from the first survey at Time 1 (n=400).

Participant Demographics

Key characteristics of the sample are summarised in Table 3.

Table 3

Participant Demographic Information

Variable		n (%)
Primary profession (N= 400)	Clinical psychologist	293 (73.25)
	Psychological wellbeing practitioner	36 (9.00)
	Cognitive behaviour therapist	28 (7.00)
	Counsellor	15 (3.75)
	High intensity therapist	14 (3.50)
	Psychotherapist	4 (1.00)
	Counselling psychologist	4 (1.00)
	Other [a]	3 (.75)
	Forensic psychologist	1 (.25)
	Health psychologist	1 (.25)
	Arts therapist	1 (.25)
Contract (N= 400)	Permanent	363 (90.75)
	Non-permanent/fixed term	31 (7.75)
	Other [b]	4 (1.00)
	Bank/zero hours	2 (.50)
Years since professional qualification (N= 400)	Up to 5 years	116 (29.00)
	5-10 years	88 (22.00)
	11-15 years	70 (17.50)
	16-20 years	61 (15.25)
	21-25 years	27 (6.75)
	26-30 years	21 (5.25)
	31-35 years	12 (30.00)
	36 years or more	5 (1.25)
Years worked since professional qualification (N= 400)	Up to 5 years	124 (31.00)
	5-10 years	84 (21.00)
	11-15 years	71 (17.75)
	16-20 years	57 (14.25)
	21-25 years	31 (7.75)
	26-30 years	17 (4.25)
	31-35 years	11 (2.75)
	36 years or more	5 (1.25)

Years in current post (N= 400)	Up to 5 years	246 (61.50)
	5-10 years	84 (21.00)
	11-15 years	45 (11.25)
	16-20 years	18 (4.50)
	21-25 years	4 (1.00)
	26-30 years	1 (.25)
	31-35 years	2 (.50)
Weekly contracted hours (N= 400)	< 7.5 hours	4 (1.00)
	7.5 - 15 hours	14 (3.50)
	> 15 hours - 22.5 hours	55 (13.72)
	> 22.5 hours - 30 hours	78 (19.50)
	> 30 hours – 37.5 hours	223 (55.75)
	> 37.5 hours	26 (6.50)
Organisation type (N= 400)	NHS	354 (88.50)
	Private/ Independent	24 (6.00)
	Third Sector/ Charitable	10 (2.50)
	Equal NHS and non-NHS	3 (.75)
	Other [c]	9 (2.25)
Agenda for Change pay scale (n=379)	Band 4	5 (1.32)
	Band 5	28 (7.39)
	Band 6	31 (8.18)
	Band 7	70 (18.47)
	Band 8a	110 (29.02)
	Band 8b	52 (13.72)
	Band 8c	52 (13.72)
	Band 8d	22 (5.580
	Band 9	6 (1.58)
	Do not wish to disclose	3 (.79)
Non-Agenda for Change pay scale (n=21)	< £10,000	1 (4.76)
	£10,001 - £20,000	1 (4.76)
	£20,001 - £30,000	1 (4.76)
	£30,001 - £40,000	3 (14.29)
	£40,001 - £50,000	0 (0)
	£50,001 - £60,000	3 (14.29)
	£60,001 - £70,000	2 (9.52)
	£70,001 - £80,000	2 (9.52)
	£80,001 - £90,000	4 (19.05)

	£90,001 - £100,000	1 (4.76)
	£100,001 - £110,000	1 (4.76)
	Do not wish to disclose	2 (9.52)
Participant gender (N= 400)	Female	324 (81.00)
	Male	73 (18.25)
	Transgender	1 (.25)
	Do not wish to disclose	2 (.50)
Participant age (N= 400)	18-24	5 (1.25)
	25-34	83 (20.75)
	35-44	142 (35.50)
	45-54	117 (29.25)
	55-64	46 (11.50)
	65-74	3 (.75)
	Do not wish to disclose	4 (1.00)
Any long-standing illness or disability (N= 400)	Yes	47 (11.75)
	No	348 (87.00)
	Do not wish to disclose	5 (1.25)

[a] Other profession: child psychotherapist and systemic family practitioner (n=1), clinical associate in applied psychology (n=1), primary mental health practitioner (n=1)

[b] Other contract: freelance (n=1), locum (n=2), self-employed in private company working for NHS (n=1)

[c] Other organisation: community interest company (n=2), university (n= 2), equal NHS and university (n=2), equal NHS and non-NHS (n=3)

Data Analysis

Characteristics of Psychological Practitioner Workplace Wellbeing Measure

Descriptive statistics for the PPWWM are shown in Table 4.

Table 4

Psychological Practitioner Workplace Wellbeing Measure Descriptive Statistics

	N	Range	Min	Max	*M*	*SD*	Median	Mode
PPWWM total score	400	82	47	129	93.47	17.67	96	101

Normality

The testing of normality established the data were non-normal as indicated by a visual inspection of the histogram (Appendix O), the z-score of skewness and kurtosis (see Table 5) and the significant Kolmogorov–Smirnov test (p= .001). Therefore, Pearson's correlations with bootstrapping tests were used in the subsequent data analyses. Bootstrapping (Efron & Tibshirani, 1993) involves estimating the properties of the sampling distribution from the sample data and produces percentile bootstrap confidence intervals based on the values between which 95% of bootstrap sample estimates fall (Field, 2018).

Table 5

PPWWM Skewness and Kurtosis

	Skewness				Kurtosis			
	Statistic	Std. Error	z	p	Statistic	Std. Error	z	P
Total PPW Score	-.27	.12	2.24	.025*	-.63	.24	2.60	.009*

* two-tailed

Correlation Analyses

A Pearson's correlation with bootstrapping was used to analyse the correlations

between the PPWWM and other measures. Correlations between the PPWWM and the

additional measures were all strongly correlated as predicted: PPWWM and HSEMS-IT, r = .88, p

< .001; PPWWM and SWLS, r = .50, p < .001; and PPWWM and GHQ-12, r = - .55, p < .001.

Internal Consistency PPWWM

Internal consistency of the PPWWM was assessed using Cronbach's α, showing high

internal consistency, α = .92. Internal consistency was also found to be stable with the deletion

of individual items (Table 6). Additionally, internal consistency was evidenced by the finding

that the items showed high or moderate corrected item-total correlations (correlations with

the total minus that item's score). Only item 26, which had a reduced range, had an item-total correlation < 0.4.

Item analysis (Table 6) enabled floor and ceiling effects to be evaluated, as indicated by item mean and standard deviation scores. All item responses ranged from 1 to 5. An item mean score close to 1, with a small standard deviation, would indicate a floor effect and an item mean score close to 5, with a small standard deviation, would indicate a ceiling effect. No items were found to have floor effects. However, item 26 indicated a high mean score with a small standard deviation. Deletion of any individual items had a minimal impact on the overall α value, as shown in Table 6.

Table 6

Individual Item Mean and Standard Deviation Scores and Internal Consistency

Item	M	SD	Corrected item-total correlation	Cronbach's α if item deleted
1	3.38	1.38	.54	.93
2	4.20	.96	.50	.94
3	3.64	1.19	.66	.93
4	3.94	.99	.45	.93
5	3.68	1.22	.65	.93
6	4.10	.96	.57	.93
7	3.55	1.13	.65	.93
8	3.08	1.27	.57	.93
9	4.03	1.13	.49	.93
10	4.00	1.12	.58	.93
11	4.26	.91	.47	.93
12	2.82	1.22	.65	.93
13	3.79	1.20	.57	.93
14	3.56	1.12	.57	.93
15	2.89	1.33	.53	.93
16	4.15	.83	.54	.93
17	3.47	1.22	.49	.93
18	2.72	1.28	.44	.94
19	4.02	1.09	.36	.93
20	3.95	1.22	.64	.93
21	3.50	1.30	.57	.93
22	3.67	1.20	.66	.93
23	2.96	1.31	.56	.93
24	2.93	1.32	.49	.93

25	2.81	1.17	.58	.93
26	4.41	.75	.37	.93

Internal Consistency of Additional Measures

An examination of all measures' internal consistency was conducted using Cronbach's α, showing high internal consistency: HSEMS-IT, α = .93; SLWS, α = .90; GHQ-21, α = .91.

Test-Retest Reliability

The PPWWM test-retest reliability was assessed with the sample of 194 participants after matching data collected at Time 1 and Time 2: 7 to 14 days after Time 1. Pearson's correlation with bootstrapping indicated a strong positive correlation, r = 0. 94, p < .001, between PPWWM score at Time 1 (M= 94.56, SD= 18.43) and PPWWM score at Time 2 (M= 95.95, SD= 16.99) demonstrating high temporal stability.

A repeated ANOVA with bootstrapping was used to determine whether mean PPWWM scores at Time 1 and mean PPWWM scores at Time 2 were significantly different, $F_{(1, 193)}$ =9.38; p = .003. Although a significant difference was found, in this large sample, a very small effect size was observed, d = .078. Effect sizes of 0.2, 0.5 and 0.8 are considered small, medium and large respectively (Cohen, 1988, 1992).

Variation in PPWWM Scores

To explore how much variation in PPWWM scores can be explained by participant demographic information, tests to assess Eta (η), F-ratios and Kendall's Tau-b (τ_b) were conducted, depending on the nature of the data (nominal, interval or ordinal). Due to multiple comparisons, a Bonferroni adjustment was required to reduce the likelihood of Type 1 errors. After Bonferroni adjustment, α = .05/ 12 = .004.

Eta analyses and one-way ANOVAs were conducted to measure association between nominal data sets and PPWWM scores as shown in Table 7. Kendall's τ_b analyses were conducted to measure association between ordinal data sets and PPWWM score as shown in Table 8. After Bonferroni adjustment across the whole set of 12 comparisons, only age was significantly correlated with PPWWM score.

Table 7

Variation in PPWWM Scores Explained by Nominal Variables

Variable	η	F (df)	Sig.
Primary profession	.14	.74 (10, 389)	.688
Type of contract	.12	2.04 (3, 396)	.108
Type of organisation	.13	1.58 (4, 395)	.179
Gender	.12	1.87 (3, 396)	.134
Illness or disability	.08	1.41 (2, 397)	.246

Table 8

Variation in PPWWM scores Explained by Interval and Ordinal Variables

Variable	τ_b	Sig.
Number of years since professional qualification	-.08	.015
Number of years worked since professional qualification	-.09	.010
Number of years worked in current post	-.03	.229
Number of contracted hours per week	.05	.085
Agenda for change pay scale	-.07	.025
Non- Agenda for change pay scale	.25	.078
Age	-.10	.003

Exploratory Factor Analysis

An exploratory factor analysis was conducted to determine the latent constructs contained in the 26-item PPWWM. Initially, the factorability of the 26 PPWWM items was examined. The Bartlett's Test of Sphericity and the Kaiser-Meter-Olkin (KMO) measure of sampling adequacy and an inspection of the correlation matrix were performed to determine whether the data could be factored.

The data were compliant with the assumptions for factor analysis. A KMO score of .5 is considered adequate for factor analysis (Kaiser, 1970 & Kaiser & Rice, 1974) and values between .7 and .8 are considered good (Field, 2018). With a KMO score of 0.90, the PPWWM was considered suitable for factor analysis. Additionally, Bartlett's Test of Sphericity indicated significance (p> .001). Therefore, the data was considered suitable for factor analysis.

An exploratory factor analysis, using Varimax rotation, was conducted. Six factors with eigenvalue greater than 1.0 were generated, explaining 61.2% of the variance (Table 9). Factors with an eigenvalue greater than 1.0 identify common factors suitable for rotation (Kaiser, 1960, cited in Field, 2018). The scree plot was also reviewed to confirm these findings (see Appendix P).

Table 9

Exploratory Factor Analysis Eigenvalues and Rotated Values

	Initial Eigenvalues			Rotation Sums of Squared Loadings		
Factor	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	9.15	35.21	35.21	4.14	15.91	15.91
2	1.69	6.50	41.71	3.15	12.10	28.01
3	1.57	6.05	47.76	2.46	9.47	37.48
4	1.37	5.28	53.03	2.22	8.53	46.01
5	1.10	4.21	57.25	2.16	8.31	54.31
6	1.03	3.98	61.22	1.80	6.91	61.22

Factor Structure and Item Loadings

There is no commonly agreed definition of what constitutes a low, medium and high item communality/loading. Field (2018) highlights, as with all significance tests, that the p-value depends on the sample size used, proposing that in very large sample sizes, even small loadings will be significant. Tabachnick and Fidell (2014) propose interpreting factors loadings with a

value greater than .32, explaining approximately 10% of the variance in the variable, while Stevens (2012) recommends interpreting factor loadings with an absolute value greater than .4, which explains approximately 16% of the variance. Costello and Osborne (2005) suggest that item communalities/loadings are most frequently between .4 and .7 in social sciences research and also propose items should have loadings of greater than .4. Considering recommendations, within this study, items with factor loadings of .4, or higher, were considered to have good communality/loading. The factor structure (Table 10) was reviewed. All items predominantly loaded onto one factor.

Costello and Osborne (2005) propose a factor with less than three items is generally unstable or weak. Therefore, Cronbach's α coefficients were not calculated for each of the six identified factors as a result of small numbers of items loading on to some factors.

Factor 1 contained nine items relating to 'professional and organisational' aspects, concerned with professional autonomy, organisational opportunities and engagement. Factor 2 contained six items relating to 'support and flexibility', concerning items relating to colleague and managerial support and control and flexibility over work. Factor 3 contained four items relating to a psychological practitioner's 'professional role', including the added value of a psychological practitioner and role clarity. Factor 4 contained two items associated with the appropriateness and impact of the 'physical environment' of the workplace. Factor 5 contained two items relating to supportive, containing and safe 'clinical supervision'. Factor 6 contained

three items relating to 'external personal' items, concerning external personal support and

work/life balance.

Table 10

Factor Structure and Item Loadings for the Six Factor Solution of the PPWWM

Item	Factor					
	1	2	3	4	5	6
7. I feel I can balance less fulfilling aspects of my job with more enjoyable aspects	.48					
8. I cannot see how the service/ organisation in which I work can ever be delivered effectively	.67					
10. I am enabled to manage and organise my workload and diary	.45					
12. I feel confident the service/ organisation in which I work can adapt to meet future service demands	.71					
18. I do not feel included in service/ organisational decisions that affect me	.52					
21. My continuing professional development needs are supported	.64					
22. I am encouraged and supported to develop my skill-set and knowledge	.60					
23. I am expected to reach unrealistic or unattainable targets	.57					
25. I feel service/ organisational targets are meaningful	.69					
2. I feel I can seek support from my colleagues		.58				
3. I feel a sense of belonging to the service/ organisation in which I work		.53				
4. Flexible working arrangements are supported in my service/organisation		.62				
5. I feel supported by my line-manager to take positive risks without fear of reproach		.70				
6. I work in an environment where my colleagues are caring and supportive towards each other		.57				
20. My line-manager is approachable and responsive		.64				

11. I am clear of my role in relation to other professionals with whom I work	.68		
14. My colleagues have realistic expectations of my professional role	.54		
16. My colleagues value my professional contribution	.70		
26. My specific skills as a psychological practitioner add value to the team/ service/ organisation	.64		
15. The physical environment and facilities in my workplace enable me to work efficiently and effectively		.84	
24. The physical environment and/ or facilities in my workplace adversely affect my workplace wellbeing		.86	
9.The clinical supervision I receive is containing and safe			.88
13. Clinical supervision meets my support needs			.86
1. I do not feel there is always someone there for me when I need personal support				.45
17. I have a good work/ life balance				.68
19. The personal support I receive from family and/or friends meets my needs				.77

Discussion

The aim of this study was to develop and validate a new psychometric measure to assess the workplace wellbeing of psychological practitioners. The results indicated the new 26-item measure has high internal consistency, construct validity and test-retest stability. As hypothesised, there were strong, positive correlations between the PPWWM and the HSEMS-IT (HSE, 2004b) and the PPWWM and SWLS (Diener et al., 1985) and a strong negative correlation between the PPWWM and GHQ-12 (Goldberg, 1992).

It is notable that the associations between PPWWM scores and SWLS scores (Diener et al., 1985) and PPWWM and GHQ-12 scores (Goldberg, 1992), although significant, were lower than the correlation between PPWWM and the HSEMS-IT (HSE, 2004b) scores. This would be expected due to factors other than workplace wellbeing contributing to life satisfaction and general health, further reinforcing the need for a workplace and profession specific measure of wellbeing. Despite the PPWWM demonstrating high test-retest reliability, a significant difference was observed between PPWWM scores at Time 1 (*M*= 94.56, *SD*= 18.43) and Time 2 *M*= 95.95, *SD*= 16.99). However, the effect size was very small and it is possible the significant difference was observed due to the large sample size. Alternatively, it is possible that there could be a small effect of repeated testing/ practice effect, but this finding requires replication to demonstrate its dependability.

After Bonferroni adjustment, no variance in PPWWM scores was observed based on discrete demographic factors, except for age. However, Bland and Altman (1996) proposed Bonferroni corrections are highly conservative and can fail to identify significant relationships,

particularly when evaluating the associations between different variables in survey-based research. If considering the association between PPWWM scores and discrete demographic factors without Bonferroni adjustment (α = .05), then additional to age, there were negative associations between PPWWM score and years since professional qualification, years worked since professional qualification and pay scale. Interestingly, the negative associations observed between PPWWM score and age, and PPWWM score and years of experience (without Bonferroni adjustment), contrast with findings within burnout literature suggesting younger, less experienced clinicians are at higher risk of experiencing burnout. For example, Dorociak, Patricia, Rupert and Zahniser (2017) proposed individuals in the first seven years of employment since obtaining their doctoral degree, 'early-career psychologists', reported higher emotional exhaustion, higher work-related demands and less professional resources than 'late-career psychologists', with over 20 years of experience in the field. However, the Dorociak et al. (2017) study was conducted in the USA and in general, studies assessing wellbeing are cross-sectional and therefore age-related trends may reflect country-specific cohort effects rather than developmental trends.

Exploratory Factor Analysis

The PPWWM produced a set of six factors from the data, explaining 61.2% of the variance within the measure: professional and organisational; support and flexibility; professional role; physical environment; clinical supervision; external personal. It is noteworthy that common themes exist in both the PPWWM and the HSEMS-IT (HSE, 2004b). Both measures

examine the work environment, control over work or professional autonomy, colleague and line-manager support and clarity of professional role within the organisation. However, despite some similarities, the PPWWM also addresses aspects specific to the role of a psychological practitioner such as clinical supervision, professional opportunities and external personal aspects which may influence workplace wellbeing. This would be expected due to the HSEMS-IT not being associated with a specific profession and assessing aspects of work design/stressors, as opposed to overall workplace wellbeing specific to psychological practitioners.

Item Analysis

Although overall PPWWM scores were not normally distributed, scores were generally well distributed. This implies that floor and ceiling effects for total PPWWM are likely to be minimised in practical applications of the measure. However, despite all items obtaining the full range of possible responses (1 to 5), item 26: 'my specific skills as a psychological practitioner add value to the team/ service/ organisation', indicated a particularly high mean score and small standard deviation. Furthermore, the deletion of any individual items had a minimal impact on the overall internal consistency of the measure and internal consistency of the PPWWM was evidenced by the high or moderate corrected-item total correlations. Item 26 showed the lowest item-total correlation of 0.37.

For preliminary development of the measure, all items were retained to reflect a broad range of aspects of psychological practitioner workplace wellbeing. However, future research

examining the utility of the PPWWM within other samples should conduct item analysis and particularly consider whether item 26 should be retained.

Limitations and Future Research

Items reflect a broad range of issues relevant to the unique aspects of workplace wellbeing of psychological practitioners. However, due to the small number of items loading on to some factors, Cronbach's α coefficients were not conducted independently for each of the six factors. Costello and Osborne (2005) propose a factor with less than three items is generally unstable or weak and Field (2018) proposes only accepting reliability of a factor if it contains four or more items. Considering this, future research should utilise confirmatory factor analysis with an independent sample to further assess the strength of the proposed factor solution.

A limitation of this study is the lack of assessment of participant ethnicity and participant professional responsibilities, for example, clinical, supervisory and managerial. These factors may influence workplace wellbeing and future research should assess the variation in PPWWM scores and utility of this measure, in relation to a wider range of personal and professional variables. Furthermore, despite no significant variance in PPWWM scores being observed based on profession or gender, it is notable that the highest percentage of respondents were female (81%) and Clinical Psychologists (73.3%) with a relatively small representation from other genders or professions. Therefore, further research should also aim to assess a more gender-equal sample and further consider other psychological practitioner professional groups to ensure the measure is generalisable and cross-validated within these

populations. Considering the initial aim of the NSP to assess the workplace wellbeing of psychological staff in IAPT services, cross-validation should be prioritised with samples of psychological wellbeing practitioners, high intensity therapists and cognitive behavioural therapists, who are frequently employed within IAPT services and have been found to have high levels of burnout (Steel et al., 2015). The PPWWM may require subsequent modification to accommodate additional workplace wellbeing factors associated with these professions.

Additionally, although no significant variance in PPWWM scores was observed based on type of organisation, further research should consider its ecological validity in different clinical settings. This will ensure the measure is comparable across different work settings, for example adult mental health, child and adolescent and older adult services. Furthermore, any variance in PPWWM scores determined by occupational tasks, such as quantity of direct therapeutic work (case-load), leadership duties or supervision responsibilities, should be considered.

Considering this study contained a sample of psychological practitioners employed in the UK, generalisability of the measure cross-nationally is not possible at present. Therefore, caution should be taken when utilising the measure within non-UK samples. Longo, Coyne & Joseph (2017) highlight the structure of wellbeing constructs can vary across cultures. For example, Schaufeli and Enzmann (1998) noted that utilising the Maslach Burnout Inventory (Maslach & Jackson (1986) North American samples of psychotherapists were found to higher levels of emotional exhaustion and depersonalisation than similar European samples.

The specificity of the measure and the ability to detect changes in workplace wellbeing associated with specific events has not yet been assessed. This would be an important area for

further research to assess the suitability of the measure for use in longitudinal designed research. Additionally, the association between PPWWM scores and non-subjective measures, such as absenteeism, staff turnover, productivity and patient care could be considered.

Implications

In 2005, Brooks and Anderson proposed there will be continued pressure on the healthcare industry to provide ever improving care with the same, or reduced resources and, consequently, it is likely this will have a detrimental impact on those providing care. Considering the potential detrimental personal, patient and organisational impacts of poor workplace wellbeing, it is essential that psychological practitioner wellbeing is appropriately monitored (NICE, 2009). It has been acknowledged there can stigma associated with healthcare professionals, including practitioner psychologists, acknowledging the need for support within the workplace (Walsh and Cormack, 1994). However, if assessment of workplace wellbeing was routinely conducted and subsequent appropriate support provided, a cultural shift may occur which enables and encourages individuals to openly address such matters. The PPWWM provides a tool to formally assess workplace wellbeing and it is hoped the measure will also promote an increased dialogue regarding psychological practitioner wellbeing.

The HSEMS-IT (HSE, 2004b) was named as an 'indicator tool' in recognition of the known limitations of structured questionnaires and the observation that no individual measure, on its own, is sufficient to assess all aspects of work-related stress (Edwards et al., 2008). Similarly, while PPWWM scores provide a useful overview of workplace wellbeing, it is advised that the measure is not used in isolation. Instead, the measure should be used alongside system-level

enquiry and individual assessment of psychological practitioner wellbeing, for example within clinical and managerial supervision. The brevity of the PPWWM means it could be incorporated into a battery of assessments, assessing a wider number of factors that have been considered in previous workplace wellbeing research including general wellbeing, job satisfaction and burnout. Furthermore, workplace wellbeing should be seen on a continuum and not as a discrete variable. Consequently, no cut off scores have been proposed within this research.

Conclusion

There are currently no validated tools to specifically measure the subjective workplace wellbeing of psychological practitioners. This research contributes to the current literature regarding the importance of healthcare professional wellbeing, by providing a valid and reliable measure. Additional research is required to further examine the proposed factor solution and to ensure the measure is sensitive to change, and valid cross-nationally and cross-professionally.

Conflict of Interest Declaration

References

Ackerley, G. D., Burnell, J., Holder, D. C., & Kurdek, L. A. (1988). Burnout among licensed psychologists. *Professional Psychology: Research and Practice*, *19*, 624-631. doi: 0735-7028/88

Bland, J. M. & Altman, D. G**.** (1996). Measurement error. *British Medical Journal,* 313, 744. doi: 10.1136/bmj.313.7059.744

Boorman, S. (2009). *NHS health and well-being: Final report* (299039). London: Department of Health.

Chmiel, M., Brunner, M., Martin, R., & Schalke, D. (2012). Revisiting the structure of subjective well-being in middle-aged adults. *Social Indicators Research*, *106*, 109-116. doi: 10.1007/s11205-011-9796-7

Cohen, J. (1988). *Statistical power analysis for the behavioural sciences* (2nd ed.) New York: Academic Press.

Cohen, J. (1992). A power primer. *Psychological Bulletin,* 112(1), 155-159. doi: 0033-2909/92

Costello, A. B., & Osborne, J. W. (2005). Best practices in exploratory factor analysis: Four recommendations for getting the most from your analysis. *Practical Assessment, Research and Evaluation*, *10*(7), 1-9. doi: 10.1.1.110.9154

Cousins, R., Mackay, C. J., Clarke, S. D., Kelly, C., Kelly, P. J., & McCaig, R. H. (2004). 'Management standards' work-related stress in the UK: Practical development. *Work & Stress*, *18*(2), 113-136. doi: 10.1080/02678370410001734322

Cushway, D., & Tyler, P. A. (1994). Stress and coping in clinical psychologists. *Stress and Health*, *10*, 35-42. doi: 10.1002/smi.2460100107

D'Souza, F., Egan, S. J., & Rees, C. S. (2011). The relationship between perfectionism, stress and burnout in clinical psychologists. *Behaviour Change*, *28*, 17-28. doi: 10.1375/bech.28.1.17

Dattilio, F. M. (2015). The self-care of Psychologists and mental health professionals: A Review and Practitioner Guide. *Australian Psychologist*, *50*(6), 393-399. doi: 10.1111/ap.12157

Department of Health. (2009). In D. Richards & M. Whyte (Eds.), National programme educator materials for support the delivery of training for psychological wellbeing practitioners delivering low intensity interventions (2nd ed.). London: Department of Health.

DeVellis, R. F. (2017). *Scale development: Theory and applications* (4th ed.). Los Angeles: Sage Publications.

Di Benedetto, M. (2015). Comment on "The self-care of psychologists and mental health professionals" (Dattilio, 2015)—Working with the mentally ill is a mental health hazard: What can we do about it?. *Australian Psychologist*, *50*(6), 400-404. doi: 10.1111/ap.12144

Di Benedetto, M., & Swadling, M. (2014). Burnout in Australian psychologists: Correlations with work-setting, mindfulness and self-care behaviours. *Psychology, Health and Medicine*, *19*, 705-715. doi: 10.1080/13548506.2013.861602

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment, 49*, 71–75. doi: 10.1207/s15327752jpa4901_13

Dimotakis, N., Scott, B. A., & Koopman, J. (2011). An experience sampling investigation of

workplace interactions, affective states, and employee well-being. Journal of

Organizational Behavior, 32(4), 572–588. doi: 10.1002/job.722

Dorociak, K. E., Rupert, P. A., & Zahniser, E. (2017). Work life, well-being, and self-care across

the professional lifespan of psychologists. *Professional Psychology: Research and*

Practice, *48*(6), 429-437. doi: 10.1037/pro0000160

Dosanjh, N. & Bhutani, G. (2017, March). Workforce Wellbeing Survey 2014-2016. Workshop

presented at the New Savoy Conference 2017: Psychological Therapies in the NHS,

London.

Eaton, J. L., Mohr, D. C., Hodgson, M. J., & McPhaul, K. M. (2018). Development and Validation

of the Work-Related Well-Being Index: Analysis of the Federal Employee Viewpoint

Survey. *Journal of occupational and environmental medicine*, *60*(2), 180-185. doi:

10.1097/JOM.0000000000001196

Edwards, J. A., Webster, S., Van Laar, D., & Easton, S. (2008). Psychometric analysis of the UK

Health and Safety Executive's Management Standards work-related stress Indicator

Tool. *Work & Stress*, *22*(2), 96-107. doi: 10.1080/02678370802166599

Efron, B. & Tibshirani, R. (1993). An Introduction to the Bootstrap, Monographs on

Statistics and Applied Probability. New York: Chapman & Hall.

Fat, L. N., Scholes, S., Boniface, S., Mindell, J., & Stewart-Brown, S. (2017). Evaluating and

establishing national norms for mental wellbeing using the short Warwick–Edinburgh

Mental Well-being Scale (SWEMWBS): findings from the Health Survey for

England. *Quality of Life Research*, *26*(5), 1129-1144. doi: 10.1007/s11136-016-1454-8

Farber, B. A. (1983). The effects of psychotherapeutic practice upon psychotherapists.

Psychotherapy: Theory, Research and Practice, *20*, 174-182. doi: 10.1037/h0088488

Farber, B. A., & Heifetz, L. J. (1981). The satisfactions and stresses of psychotherapeutic work: A

factor analytic study. *Professional Psychology*, *12*, 621-630. doi: 10.1037/0735-

7028.12.5.621

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G* Power 3: A flexible statistical power

analysis program for the social, behavioral, and biomedical sciences. *Behavior research*

methods, *39*(2), 175-191. Retrieved from

https://link.springer.com/content/pdf/10.3758%2FBF03193146.pdf

Field, A. (2018). *Discovering statistics using IBM SPSS Statistics* (5th ed.) London: Sage

Publications.

Firth-Cozens, J. (2001). Interventions to improve physicians' well being and patient care. *Social*

Science and Medicine, 52, 215–222. doi: 10.1016/S0277-9536(00)00221-5

Goldberg, D. (1978). *General Health Questionnaire (GHQ-60).* Windsor: NFER-NELSON

Goldberg, D. (1992). *General Health Questionnaire (GHQ-12).* Windsor: NFER-NELSON

Gunderson, L. (2001). Physician burnout. *Annals of Internal Medicine, 135*(2), 145-148. doi:

10.7326/0003-4819-135-2-200107170-00023

Glasper, A. (2010). Promoting wellbeing: Productive and healthy working conditions. *British*

Journal of Nursing, *19*(1), 1262-1263. doi: 10.12968/bjon.2010.19.1.45904

Hankins, M. (2008). The reliability of the twelve-item general health questionnaire (GHQ-12) under realistic assumptions. *BioMed Central Public Health*, *8*(355), 1-7. doi: 10.1186/1471-2458-8-355

Hardy, G. E., Shapiro, D. A., Haynes, C. E., & Rick, J. E. (1999). Validation of the General Health Questionnaire-12: Using a sample of employees from England's health care services. *Psychological Assessment*, *11*(2), 159-165. doi: 1040-3590/99

Health and Safety Executive. (n.d.). Management Standards Analysis Tool. 153 User Manual. Retrieved from http://www.hse.gov.uk/ stress/standards/downloads.htm

Health and Safety Executive. (2004a). *Working together to reduce stress at work: A guide for employees*. (Leaflet INDG424). Retrieved from www.hse.gov.uk/pubns/indg424.pdf

Health and Safety Executive (HSE). (2004b). *Management Standards Indicator Tool.* Retrieved from www.hse.gov.uk/stress/ standards/pdfs/indicatortool.pdf

Johnson, S., Cooper, C., Cartwright, S., Donald, I., Taylor, P., & Millet, C. (2005). The experience of work-related stress across occupations. *Journal of managerial psychology*, *20*(2), 178-187. doi: 10.1108/02683940510579803

Kaiser, H. F. (1960) The application of electronic computers to factor analysis. *Educational and Psychological Measurement, 20,* 141-151 cited in Field, A. (2018). *Discovering Statistics using SPSS, 5th Edition.* London: Sage Publications.

Kaiser, H. F. (1970). A second-generation little jiffy. *Psychometrika, 35*, 401-415. doi: 10.1007/BF02291817

Kaiser, H. F. & Rice, J. (1974). Little jiffy, mark 4. *Educational and Psychological Measurement, 34*(1), 111-117. doi: 10.1177/001316447403400115

Kerr R., McHugh M., & McCory M. (2009). HSE Management Standards and stress-related work outcomes. *Occupational Medicine, 59*, 574–579. doi: 10.1093/occmed/kqp146

Larsen, R.J., Diener, E., & Emmons, R.A. (1985). An evaluation of subjective well-being measures. *Social Indicators Research, 17*, 1–18. doi: 10.1007/BF00354108

Lasalvia, A., Bonetto, C., Bertani, M., Bissoli, S., Cristofalo, D., Marrella, G., … & Marangon, V. (2009). Influence of perceived organisational factors on job burnout: survey of community mental health staff. *The British Journal of Psychiatry*, *195*(6), 537-544. doi: 10.1192/bjp.bp.108.060871

Linton, M. J., Dieppe, P., & Medina-Lara, A. (2016). Review of 99 self-report measures for assessing well-being in adults: exploring dimensions of well-being and developments over time. *BMJ open*, *6*(7), 1-16. doi: 10.1136/bmjopen-2015-010641

Longo, Y., Coyne, I., & Joseph, S. (2017). The scales of general well-being (SGWB). *Personality and Individual Differences*, *109*, 148-159. doi: 10.1016/j.paid.2017.01.005

Lundin, A., Hallgren, M., Theobald, H., Hellgren, C., & Torgén, M. (2016). Validity of the 12-item version of the General Health Questionnaire in detecting depression in the general population. *Public health*, *136*, 66-74. doi: 10.1016/j.puhe.2016.03.005

Maslach, C., & Jackson, S.E. (1986). *Maslach burnout inventory manual* (2nd ed.). Palo Alto,

California: Consulting Psychologists Press.

Maslach, C., Jackson, S.E., & Leiter, M.P. (1996). *Maslach Burnout Inventory manual* (3rd ed.).

Palo Alto: Consulting Psychologists Press.

National Institute for Health and Clinical Excellence. (2009). *Mental wellbeing at work* (Public

Health Guideline ph22). London. NICE.

New Economics Foundation. (2009). National Accounts of Well-being: Bringing real wealth onto

the balance sheet. Retrieved from

http://b.3cdn.net/nefoundation/2027fb05fed1554aea_uim6vd4c5.pdf

Norcross, J. C., & Guy, J. D., Jr. (2007). *Leaving it at the office: A guide to psychotherapist self-*

care. New York: Guilford Press.

O'Donnell, G., Deaton, A., Durand, M., Halpern, D., & Layard, R. (2014). Wellbeing and Policy:

Legatum Institute. Retrieved from https://lif.blob.core.windows.net/lif/docs/default-

source/commission-on-wellbeing-and-policy/commission-on-wellbeing-and-policy-

report---march-2014-pdf.pdf?sfvrsn=0

Oates, J., Jones, J., & Drey, N. (2017). Subjective well-being of mental health nurses in the

United Kingdom: Results of an online survey. *International Journal of Mental Health*

Nursing, *26*, 391-401. doi: 10.1111/inm.12263

Pavot, W. & Diener, E. (2008). The satisfaction with life scale and the emerging construct of life

satisfaction. *The Journal of Positive Psychology, 3*, 137–152. doi:

10.1080/17439760701756946

Pavot, W., Diener, E., Colvin, C. R., & Sandvik, E. (1991). Further validation of the satisfaction

with life scale: Evidence for the cross-method convergence of well-being measures.

Journal of Personality Assessment, 57(1), 149–161. doi: 10.1207/s15327752jpa5701_17

Picardi, A., Abeni, D., & Pasquini, P. (2001). Assessing psychological distress in patients with skin

diseases: reliability, validity and factor structure of the GHQ-12. *Journal of the European*

Academy of Dermatology and Venereology, *15*(5), 410-417. doi: 10.1046/j.1468-

3083.2001.00336.x

Piccinelli, M., Bisoffi, G., Bon, M. G., Cunico, L., & Tansella, M. (1993). Validity and test-retest

reliability of the Italian version of the 12-item General Health Questionnaire in general

practice: a comparison between three scoring methods. *Comprehensive*

Psychiatry, *34*(3), 198-205. doi: 10.1016/0010-440X(93)90048-9

Rizq R. (2012). The perversion of care: Psychological therapies in a time of IAPT. *Psychodynamic*

Practice, 18, 7-24. doi: 10.1080/14753634.2012.640161

Ruiz, F. J., García-Beltrán, D. M., & Suárez-Falcón, J. C. (2017). General Health Questionnaire-12

validity in Colombia and factorial equivalence between clinical and nonclinical

participants. *Psychiatry Research*, *256*, 53-58. doi: 10.1016/j.psychres.2017.06.020

Rupert, P. A., & Kent, J. S. (2007). Gender and work setting differences in career-sustaining

behaviors and burnout among professional psychologists. *Professional Psychology:*

Research and Practice, *38*, 88-96. doi: 10.1037/0735-7028.38.1.88

Rupert, P. A., & Morgan, D. J. (2005). Work setting and burnout among professional

psychologists. *Professional Psychology: Research and Practice*, *36*, 544–550. doi:

10.1037/0735-7028.36.5.544

Shanafelt, T.D., Bradley, K.A., Wipf, J.W., & Back, A.L. (2002). Burnout and self-reported patient

care in an internal medicine residency program. *Annals of Internal Medicine, 136*, 358-

367. doi: 10.7326/0003-4819-136-5-200203050-00008

Schaufeli, W., & Enzmann, D. (1998). *The burnout companion to study and practice: A critical*

analysis. Philadelphia: Taylor & Francis.

Schulte, P., & Vainio, H. (2010). Well-being at work–overview and perspective. *Scandinavian*

journal of work, environment & health, 422-429. Retrieved from

http://www.jstor.org/stable/40967878

Smith, P. L., & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented,

and what can be done to address it?. *Clinical Psychology: Science and Practice*, *16*, 1-15.

doi: 10.1111/j.1468-2850.2009.01137.x

Steel, C., Macdonald, J., Schröder, T., & Mellor-Clark, J. (2015). Exhausted but not cynical:

burnout in therapists working within Improving Access to Psychological Therapy

Services. *Journal of Mental Health*, *24*(1), 33-37. doi: 10.3109/09638237.2014.971145

Stevens, S. (2014). Five Year Forward View. London: NHS England.

Stevens, J. P. (2012). *Applied multivariate statistics for the social sciences*. New York: Routledge.

Tabachnick, B. G., & Fidell, L. S. (2014). *Using multivariate statistics* (6th ed.). Essex, UK: Pearson

 Education Limited.

Tinsley, H. E., & Tinsley, D. J. (1987). Uses of factor analysis in counseling psychology

 research. *Journal of Counseling Psychology*, *34*(4), 414. doi: 10.1037/0022-

 0167.34.4.414

Van Laar, D., Edwards, J. A., & Easton, S. (2007). The Work-Related Quality of Life Scale for

 healthcare workers. *Journal of advanced nursing*, *60*(3), 325-333. doi: 10.1111/j.1365-

 2648.2007.04409.x

Walsh, S., & Cormack, M. (1994). 'Do as we say but not as we do': Organizational, professional

 and personal barriers to the receipt of support at work. *Clinical Psychology &*

 Psychotherapy, 1(2), 101-110. doi: 1063-3995/94/020101-10

Werneke, U., Goldberg, D. P., Yalcin, I., & Üstün, B. T. (2000). The stability of the factor

 structure of the General Health Questionnaire. *Psychological Medicine*, *30*(4), 823-829.

 doi: 10.1017/S0033291799002287

Williams, E.S., & Skinner, A.C. (2003). Outcomes of physician job satisfaction: A narrative

 review, implications and directions for future research. *Health Care Management*

 Review, 28, 119–140. doi: 10.1097/00004010-200304000-00004

Wise, E. H., Hersh, M. A., & Gibson, C. M. (2012). Ethics, self-care and wellbeing for

 psychologists: Reenvisioning the stress-distress continuum. *Professional Psychology:*

 Research & Practice, *43*(5), 487-494. doi: 10.1037/a0029446

Paper 3 has been prepared in accordance with the American Psychological Association author guidelines.

Paper 3: A reflective paper providing a critical appraisal of the systematic review and empirical study

Summers, E. M. A.[1]

[1] South Wales Doctoral Programme in Clinical Psychology, Cardiff University, Cardiff, CF10 3AT

Word count (excluding references): 8301

Introduction

Paper 3 is a commentary and is not intended for publication. This paper presents a critical appraisal of paper 1 and paper 2, including a reflection on the process of conducting the research, methodologies used, and conclusions drawn. How this research contributes to the evidence base, implications of the findings and suggestions for future research are also discussed. Finally, reflections on personal and professional development are offered.

Paper 1: Systematic Review

Rationale for topic

A systematic review enables the coherent assimilation of evidence from a variety of sources in a well-defined and transparent manner, in order to answer specific research questions, critically appraise the findings and draw relevant conclusions (Charrois, 2015). When considering a systematic review topic, I was initially guided by the aims of the empirical study which I had begun conducting. I hoped to carry out a systematic review which complemented the empirical paper and provided evidence-based context for the measure development.

Initially, scoping searches were conducted on electronic databases (PsycINFO, Web of Science) to broadly review the existing literature. Existing reviews in the area of psychological practitioner workplace wellbeing were identified, including those examining: the association between healthcare professional wellbeing and burnout, with patient safety (Hall, Johnson, Watt, Tsipa & O'Connor, 2016); factors contributing to stress, burnout and job satisfaction and

stress management in UK clinical psychologists (Hannigan, Edwards & Burnard, 2004); and

system level interventions to support healthcare professional wellbeing (Brand et al., 2017).

Considering the existing research, my first line of enquiry was to identify any existing

measures relating to employee wellbeing at work utilised within healthcare settings. However,

as described in paper 2, there is widespread variation in the assessment of workplace and/or

employee wellbeing and the majority of research in this area has utilised measures assessing

general wellbeing, job satisfaction, stress, negative effect, burnout or quality of working life

(Dimotakis, Scott & Koopman, 2011). A number of employee wellbeing or 'work related quality

of life' measures have been developed for use in commercial or business settings (e.g.

Almarshad, 2015). However, there is a dearth of measures to specifically assess work-related

wellbeing, or even more broadly, work-related experiences, in healthcare professionals. Two

measures identified in the literature were the 'Work-Related Quality of Life' (WRQoL) scale for

healthcare workers (Van Laar, Edwards & Easton, 2007), assessing life and job satisfaction and

the 'Quality of Nursing Work Life' measure (Brooks, 2001), assessing four key areas: the work

life/home life interface; work design; work context; and work world.

It became clear that there are too few quantitative tools designed to assess aspects of

workplace wellbeing in healthcare professionals to be able to conduct a systematic review in

this area. Therefore, I attempted to refine, expand or adapt my research question, considering

alternative lines of enquiry. For example, I considered the quantitative assessment of general or

workplace wellbeing of psychological practitioners. This has surprisingly received very little

attention other than through the New Savoy Partnership (NSP) and Division of Clinical

Psychology (DCP) Leadership and Management Faculty annual surveys and was therefore also deemed unviable.

While conducting scoping searches, I was aware of the frequently used term 'burnout' within literature regarding healthcare professional wellbeing. I therefore initially conducted a search relating to prevalence and correlates of burnout in psychological practitioners (any professionally qualified practitioner working in a psychological/ psychotherapy profession). This yielded over 7000 records across four databases and was thought to be too broad for the scope of this review. Therefore, the decision was made to refine the professional criteria and to assess prevalence and correlates of burnout in practitioner psychologists. This was deemed to be of value to the evidence base and at this time, to my knowledge, there were no other reviews reporting solely on the prevalence and correlates of burnout in practitioner psychologists.

Inclusion and Exclusion Criteria

The systematic review included studies of cross-sectional, quantitative design, reporting prevalence of burnout, and correlates where appropriate, utilising validated measures, within qualified practitioner psychologists, working with clinical populations.

Unpublished studies may be of lower methodological quality than published studies (Egger, Juni, Bartlett, Holenstein, & Sterne, 2003) and the peer-review process is widely seen as increasing the quality of publications (Ware & Monkman, 2008). Therefore, I elected to exclude unpublished literature from the review, including academic theses and conference proceedings. This decision was made following discussion with my academic supervisor and a University

librarian. However, a weakness of this decision is that this could have introduced publication bias, as studies with large sample sizes, significant, or more favourable findings are more likely to be published (Dwan et al., 2008).

Another factor which may have created bias in the study selection was a lack of resources available allowing me to consider research that was not published in the English language. When screening the retrieved abstracts, 12 papers were identified and removed as they were unavailable in English. Consequently, potentially relevant studies, published in other languages may have fit in the inclusion/exclusion criteria and been overlooked.

I elected to exclude studies which included professionals other than practitioner psychologists within their sample. This was owing to difficulties differentiating results specific to different professional groups within such research. Furthermore, studies that included practitioner psychologists working in solely non-clinical settings (e.g. research or university), or studies which did not state participant professional work setting were excluded from the review. This was due to the differing demands placed on psychological practitioners working within clinical settings compared to those in research, university or non-clinical settings.

No date restriction was placed on studies and those reviewed spanned almost three decades. This could be deemed to be a limitation of the review considering the role of a practitioner psychologist may have changed during this period of time. For example, in the UK, in 1977, a report on the role of clinical psychologists in the National Health Service (NHS) was conducted (Trethowan, 1977). Trethowan, stated the core skills and roles of clinical psychologists were clinical skills, research and teaching. Over three decades later, the DCP

stated the core competences of a clinical psychologist are: transferable skills; psychological assessment; psychological intervention; audit and evaluation; research; personal and professional skills; communication and teaching skills (BPS, 2010). Although these roles and competencies may seem to differ minimally, it has also recently been suggested that an integral part of a clinical psychologist's role is to provide consultation and supervision, which may have been less formally stipulated historically (BPS, 2015). Furthermore, In England, with the introduction of the Improving Access to Psychological Therapies (IAPT) programme, there has been a significant rise in the number of practitioners who are trained specifically to deliver psychological therapies. In my personal experience, I am aware of many anecdotal reports suggesting that since the introduction of IAPT, clinical psychologists are now more frequently expected to hold leadership roles with a reduced focus on direct therapeutic work.

It is noteworthy that not all factors which were examined as potential correlates of burnout in the reviewed studies were reported within this systematic review. This was due to the aims and scope of the review and the inability to draw valid conclusions based on associations reported in only one study. Therefore, the review focused on specific personal demographic factors and work-related variables: age and burnout, years in service and burnout, working hours and burnout, gender and burnout, and work setting and burnout.

Literature Search

The literature search was conducted in line with the principles of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Statement to ensure the

search was methodical and transparent (Moher, Liberati, Tatzlaff & Altman, 2009). Four databases were searched: PsycINFO, ASSIA, Web of Science and Scopus. These databases were selected as they contain journals which focus on psychology and social sciences and were likely to contain research relevant to this topic.

Based on the scoping exercises conducted prior to establishing a review question, a list of search terms was created. Charrois (2015) proposed when conducting a systematic review, that in order to ensure a thorough and complete search of the literature, assistance from a librarian, with expertise in the area of systematic reviews, is advised. I therefore contacted and met with a University librarian, who assisted with defining the search terms, search strategies, and databases to be used. This ensured I had considered all truncations and utilised the databases to their maximum potential.

While conducting the scoping searches, I became aware that research often considered the concepts of stress and burnout in conjunction with each other. Considering the overlaps within research between these concepts, it was decided the term stress would be searched in addition to burnout. However, this term was searched only within the title of articles owing to the vast quantity of research conducted in relation to stress, particularly research relating to the therapeutic role of a practitioner psychologist, rather than stress within practitioners themselves. Furthermore, elements that are thought to contribute to burnout could have also been searched independently, for example, emotional exhaustion, depersonalisation and a lack of personal accomplishment (Maslach & Jackson, 1981). This could be seen as a limitation of the review.

When conducting the initial scoping searches, it became apparent that there is an abundance of research investigating burnout in school psychologists, particularly in the United States of America (USA). Considering the inclusion criteria within this review, where possible, based on database parameters, the term 'school psychologist' was excluded from the searches.

A further limitation of this review is that only one individual reviewed the search streams. Having two or more reviewers is recommended to enhance objectivity and reduce the possibility of errors in the screening process, for example, rejecting relevant studies (Moher et al., 2009).

Quality Assessment

When conducting a systematic review, the methodological quality of included studies should be assessed to ascertain the level of bias or error in the study design, conduct and analysis (Centre for Reviews and Dissemination; CRD, 2009). It is essential to use an appropriate quality assessment tool to ascertain the overall quality of the research (Sanderson, Tatt & Higgins, 2007). However, despite there being a wide range of published quality assessment tools (Jarde, Losilla & Vives, 2012), following an extensive search, it appeared there are limited recommended assessment tools that provide a quality rating score for cross-sectional studies. Considering this, I chose to adapt pre-existing tools and developed a new tool and sensitive scoring guide based on the criteria of importance identified by Greenhalgh and Brown (2014, cited in Boland, Cherry & Dickson, 2014) and The Joanna Briggs Institute guidelines for cross-

sectional and prevalence studies (The Joanna Briggs Institute, 2016; 2017) (see appendix C for tool). The scoring guide was designed to enable quality differentiation for each criterion.

The benefit of developing a new quality assessment tool was the ability to ensure the tool assessed appropriate domains of methodological quality relevant to the design of the studies reviewed. However, the use of a non-validated tool could also be deemed a limitation of this review, as the content and construct validity and inter-rater reliability are unknown. However, to ensure there was no bias in the quality assessment ratings, 25% of the studies were reviewed by an independent reviewer. Some minor differences in ratings were observed between reviewers. These differences were discussed until a consensus was met. Inter-rater reliability could have been conducted, using a Kappa statistical test to further review the agreement between reviewers.

The quality assessment tool was used with awareness that additional limitations may exist outside those identified by the tool. However, this method allowed me to consider the relative strengths and weakness of each study reviewed. It is not standard practice to exclude relevant studies that do not meet certain methodological criteria (CRD, 2009) and therefore all studies were retained regardless of quality assessment score.

A common methodological problem observed in the reviewed studies was that only half the studies fully or partially addressed the management of missing data. However, the most frequently identified methodological problem, identified in all the studies, was the lack of an explanation of the representativeness of the participant sample. Although five of the eight studies reported the percentage of respondents, no information was provided regarding those

individuals who chose not to participate. As highlighted within the review, it is important to

note that individuals choosing to participate in burnout-related research may not be a

representative sample. Karasek and Theorell (1990) described this as the healthy worker effect:

the underestimation of levels of burnout due to research only targeting relatively 'healthy'

individuals within the working population. Those that are unable to work as a result of poor

wellbeing or burnout are unlikely to be included in the normative sample, suggesting research

in this area is likely to underestimate levels of burnout within the profession.

Data Extraction

A range of measures of burnout and methods of analysis were used within the reviewed

studies. Therefore, conducting a meta-analysis was not possible and instead a narrative

synthesis of the literature was conducted. Creating a clearly structured spread sheet to

combine the data from the reviewed studies, enabled me to filter the data and obtain relevant

information for this review.

Implications for Theory and Practitioners

This review highlights fundamental difficulties with ascertaining prevalence of burnout.

This is due to the lack of a clear definition of burnout and inconsistencies around whether the

concept should be classified as a psychiatric 'disorder' or viewed on a continuum. Despite

Maslach and Jackson (1986) cautioning against the use of cut-off scores for diagnostic purposes

for the Maslach Burnout Inventory-Human Services Survey (MBI-HSS), the publication of cut-off scores within their early work has served as a motivating factor for their use. There is a strong tendency for many researchers to differentiate between 'burned-out' subjects and non 'burned-out' individuals and research often reports on prevalence of burnout using these cut-off scores. For example, a systematic review of burnout in emergency nurses reported approximately 26% of emergency nurses were experiencing burnout (Adriaenssens, De Gucht & Maes, 2015). Schaufeli and Van Dierenddonck (1995) propose that in some countries, particularly where insurance claims might be involved, there is a strong desire to diagnose individuals as 'burned out' or not, in order to decide on appropriate 'treatment'. Therefore, caution should also be taken when comparing levels of burnout cross-nationally.

Regardless of the difficulties ascertaining a clear definition of burnout, the review demonstrated that younger and less experienced individuals appeared to be at increased risk of personal burnout, work-related burnout, client-related burnout, overall burnout, emotional exhaustion and depersonalisation of clients, in comparison with their older or more experienced colleagues. Additionally, those working longer hours also appear to be at increased risk of emotional exhaustion and depersonalisation of clients.

The finding that younger and less experienced individuals are at increased risk of burnout, and associated dimensions, supports the findings of Dorociak, Rupert and Zahniser (2017) who suggest that early-career psychologists experience lower levels of professional wellbeing, greater feelings of being overwhelmed by their caseloads and greater perceived stress, relative to their more senior counterparts. Considering these findings, it would be advisable for both individual and system level strategies to be employed to support newly

137

qualified and early-career psychologists. For example, at a system level, Dorociak et al. (2017) and Norcross and Guy (2007) suggest establishing mentoring programmes as an effective way to support this professional group and promote professional and personal wellbeing.

On an individual level, it is important to acknowledge the importance of clinical supervision and personal benefits that could be derived from this in relation to personal wellbeing. The Department of Health (DoH; 1993) defines supervision as:

A formal process for professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety in complex situations. It is central to the process of learning and scope of the expansion of practice and should be seen as a means of encouraging self-assessment, analytical and reflective skill. (DoH, 1993)

Although there is no legal requirement for practitioner psychologists to engage in clinical supervision, it is considered an essential part of good professional practise (BPS, 2008; 2017). The BPS state their position is "for safe and effective practice in clinical and mental health settings, or with other vulnerable groups, supervision is a requirement of practice" (BPS, 2017, p. 13). The DCP (2014) propose that the amount and frequency of supervision is dependent on context, work demands and clinician experience. However, they recommend that newly qualified clinical psychologists should have weekly supervision for a minimum of 1 hour, mid-career clinical psychologists should have fortnightly supervision for a minimum of 1 hour and senior clinical psychologists should have a minimum of 1 hour of supervision per month

(BPS, 2014). These recommendations acknowledge the need for increased support for less experienced clinicians.

In addition to the clinical benefits, for example, the support of competency development and provision of consultation on client work, clinical supervision should provide a space for clinicians to reflect on the personal impact of work and should promote the personal responsibility for appropriate self-care and effective coping strategies (BPS, 2017). Supervision may also provide an opportunity for clinicians to reflect on their case-load management and the number of hours worked, of which the latter has been found to be associated with emotional exhaustion and depersonalisation of clients.

The importance of self-care for practitioner psychologists is frequently addressed within literature. For example, Smith and Moss (2009) propose that self-care is the most important element in the prevention or diffusing of distress and impairment in professional psychologists. Similarly, Barnett and Cooper (2009) propose that attention to ongoing self-care, self-awareness and self-reflection and the avoidance of maladaptive coping strategies should be viewed as essential responsibilities of all professional psychologists. Barnett and Cooper (2009), proposed in order to promote a culture of self-care within the profession, developing and encouraging self-care strategies should begin as early as possible and should be particularly encouraged during professional training. However, in 2006, Munsey surveyed almost 500 American psychology graduate students, indicating 83% of participants reported that educational materials about self-care were not distributed by their training programmes and 59% believed their training programmes did not informally promote or encourage self-care (Munsey, 2006). These findings are concerning and may provide an explanation for Dorociak et

al.'s (2017) findings suggesting that early-career psychologists have been found to engage in less self-care than late-career psychologists.

In addition to the importance of self-care, it is essential that practitioner psychologists, and in fact all healthcare professionals feel they can seek support within the workplace. Although now dated research, Walsh and Cormack (1994) conducted a two-stage study aiming to identify both the attitudes and practices of clinical psychologists towards receiving support within the workplace. Results identified themes explaining clinical psychologists' reluctance to seek support including: the fear of being a client, the fear of being seen as unable to cope and the perceived costs of the support process itself, for example feeling that accepting support may create a threat to job security. Attitudes of shame, as well as fears about confidentiality and the costs of help seeking have also been reported within medical professionals. For example, Chew-Graham, Rogers and Yassin (2003) explored medical students' attitudes to help-seeking. They proposed that the avoidance of appropriate help-seeking behaviour in the medical profession starts early and is associated with the perception that experiencing any difficulties relating to mental health may be viewed as a weakness and impact on future career progression.

It appears there is stigma associated with acknowledging the need for support and a culture of 'not talking' about personal and professional difficulties. If the monitoring and assessment of workplace wellbeing were routinely conducted within healthcare professional settings and subsequent appropriate support provided, a cultural shift may occur which enables and encourages individuals to openly discuss these matters. Furthermore, the provision of a psychologically safe workplace would support the ability to talk openly about difficulties or

concerns, to seek and receive feedback and take risks without fear of reproach (Edmonson, 1999).

Irrespective of the theoretical and classification difficulties surrounding the concept of burnout, it is important to keep in mind why there is interest in healthcare professional burnout and wellbeing. Ultimately, the issue of practitioner psychologist wellbeing needs to be taken seriously, considering the strong links between healthcare professional wellbeing, including burnout, and adverse personal experiences, organisational performance and patient outcomes (Rao, Bhutani, Clarke, Dosanjh & Parhar, n.d.).

Future Research

Recommendations for further research are fully outlined in the systematic review. As previously discussed, future research should aim to ascertain the representativeness of the studied participant sample. Another key area for future research is the use of longitudinally designed studies to allow a direct comparison between younger or newly qualified psychologists and those with more experience, by assessing the same participants at different stages in their careers.

Personal and Professional Reflections

Completing a systematic review has enabled me to develop my skills of synthesising and summarising a large quantity of data and information. I have also developed an appreciation of

the need to adopt a clear literature search strategy to enable the effective assessment of study inclusion and exclusion. Initially I found it challenging to assimilate the information obtained from the quality assessment rating with the results from each study. However, I was reassured that this was a common difficulty: Charrois (2015) proposes that often, the main area of difficulty for researchers is how to incorporate quality information into the data analysis.

Conducting the systematic review has also developed my confidence in critically reviewing literature and research. In particular, designing a quality rating tool and performing the quality assessment, highlighted the significant range in quality of published studies and helped inform and guide my execution of the empirical study.

From a personal perspective, I feel the findings in this review, indicating younger and less experienced psychologists may be at risk of higher levels of burnout than their more senior colleagues, are unsurprising. I am of the opinion there is a significant transition to manage when moving from trainee *status* to qualified practitioner. With this transition comes a considerable increase in personal and professional responsibility, alongside the professional development and consolidation of skills learnt throughout training. Furthermore, in my personal experience as an observer, clinical supervision for newly qualified clinical psychologists is not always undertaken as frequently as recommended and therefore newly qualified psychologists may not be receiving the level of support required to manage this transition. Considering the findings of this review, I will endeavour to take personal responsibility for engaging in self-care, seeking appropriate support as required, both as a newly qualified psychologist and throughout my career.

Paper 2: Empirical Study

Rationale for Topic

I have always had an interest in what motivates people to work in healthcare settings and the personal impact of working as a healthcare professional. Prior to starting the Doctorate of Clinical Psychology programme, I worked as an honorary research assistant in an employee wellbeing service where I further developed my interest in this area. This role involved supporting small scale research projects and developing accessible information on key wellbeing topics for the organisation website. At this time, I jointly conducted a project investigating the day to day experiences and challenges faced by nurses in the Emergency Department, promoting the development of coping and support mechanisms to encourage employee wellbeing: 'Surviving on the front line: The importance of psychological support in the Emergency Department' (Jones & Summers, 2013). This was presented in poster format at the 2013 DCP Annual Conference: 'Taking Care, Giving Care'.

The opportunity to conduct the empirical study was initiated by the NSP and the DCP Leadership and Management Faculty collaboration. One of the core objectives of this collaboration was to conduct an annual assessment of the wellbeing of the psychological workforce in the UK. During the first three years of the survey delivery, the results received national attention and interest. For example, The Rt. Hon. Alistair Burt MP, Minister of State for Community and Social Care at the Department of Health from May 2015 to July 2016 stated:

I want to be very confident that psychological therapy services can be carried by their staff, which is why I take very seriously the findings of the survey on staff wellbeing …

I'm very disappointed at elements of the survey … I can't be on platforms day in day out

talking about a world-leading service if I'm standing on something that's rusting away

beneath me … it can't be done unless *you* feel valued and unless you feel your

wellbeing *is* taken seriously (Rt. Hon. Alistair Burt MP, 2016)

However, following three years of conducting an annual survey, in 2014, 2015 and 2016,

the collaborative working group identified the need for a robust and validated measure of

workplace wellbeing, since previous surveys had utilised non-validated measures. Considering

my interest in healthcare professional wellbeing, when the opportunity arose to develop the

new measure I was highly motivated to undertake this project.

Methodology

The methodology used for the development of the Psychological Practitioner Workplace

Wellbeing Measure (PPWWM) was informed by the work of DeVellis (2017). This was a two-

phase project: Phase 1 of the measure development, the qualitative phase (McLellan, in

submission), was conducted independently of Phase 2.

Recruitment and Selection Bias

In the early stages of the measure development, I relied on contacting psychological

practitioners who were professional acquaintances and whom I was aware had an interest in

employee wellbeing, to invite them to participate in the measure development. I had

underestimated the difficulty I would face arranging a focus group, requiring an excess of 1.5 hours of clinician time. On reflection, I could have utilised video conferencing software to conduct the focus group which would have made participation more accessible and increased the numbers of clinicians participating in this stage of measure development.

Furthermore, it is notable that the focus group was conducted with clinicians who were all employed within the NHS in Wales. There are considerable differences between the service structures in the NHS England and in NHS Wales (for full review see, Wright, 2012). At present, a key difference is the existence of IAPT services in England, but not in Wales. The initial aim of the NSP, in 2009, was to assess the wellbeing of psychological therapies staff and managers in the NHS following the national roll-out of IAPT services in England. This was thought to be the 'canary in the coal-mine' for whether the IAPT programme was succeeding and able to meet its targets sustainably (New Savoy Partnership, n.d.). Although I am unaware of specific research detailing differences between the role of psychological practitioners in England and Wales, it could be suggested that psychological practitioners in England face different pressures, challenges or stressors to those practicing in Wales. Psychological practitioners in England, therefore, may have prioritised different factors when reviewing the proposed items for the measure.

Despite this limitation of the focus group, the later stages of the measure development and validation were completed by clinicians from across the UK. Although participant's location was not recorded within the demographic survey on the main study, this was evident, based on the email address domains provided by participants who opted to take part in the completion of the PPWWM at Time 2 (e.g. sompar.nhs.uk, Somerset; beh-mht.nhs.uk, Barnet Enfield and

Haringey; belfasttrust.hscni.net, Belfast; northerntrust.hscni.net, Northern Ireland). Future research could compare the utility of the PPWWM across different countries within the UK.

For the main study, the validation of the new measure, an invitation to participate was disseminated via the Psychological Professions Network (PPN) North West and DCP mailing lists, shared within professional networks and within a closed social media group of clinical psychologists working within the UK. The PPN North West was established in 2013 by senior psychological practitioners and commissioners, with support and funding from Health Education England. Membership is free and open to all practitioners whose primary role is to deliver psychological therapies and services in the North West of England. However, individuals working beyond this geographical area are also able to register. The network aims to bring together a wide range of qualified and trainee practitioners working in psychological professions, to act as a hub for professional information, education, research and development and networking. The invitation to participate in this research was sent to participants within a weekly newsletter. At this time the PPN had approximately 2250 members who would have received the invitation. However, it is unknown how many of these participants were qualified psychological practitioners and therefore eligible to participate in the survey.

The DCP is a subsection of the British Psychological Society which promotes the professional interests of clinical psychologists across the UK. At the time of conducting this research, there were approximately 10,400 DCP members, 6500 of which were practitioner psychologists. The invitation to participate was sent to the DCP mailing list. However, individuals are required to opt in to receive email correspondence and therefore, it is unknown

how many of these individuals would have received the invitation to participate and been eligible to participate based on professional qualification.

A limitation of the recruitment process was the restricted range of professionals that were likely to have received the invitations to participate. The highest percentage of respondents in all stages of the measure development, and particularly in the main study, were clinical psychologists (73.3%), with a relatively small representation from other professions. Additional professional networks and bodies could have been contacted, for example, the British Association for Behavioural and Cognitive Psychotherapies, the Association for Family Therapy and Systemic Practice and the British Association for Counselling and Psychotherapy. However, because of the limited time available to complete the research this was not possible. Future research should further establish the utility of the PPWWM within a wider range of professional groups.

Prior to beginning the measure development, through discussions with my supervisors, I decided that preliminary development of the PPWWM would focus on the workplace wellbeing of qualified psychological practitioners only. Therefore, unqualified professionals, for example, trainee clinical psychologists, assistant psychologists and trainee high intensity therapists were not eligible to participate in the measure development or validation of the new measure. This decision was made with an awareness that these groups of individuals also face potential challenges in the workplace, and workplace wellbeing of these groups is also of significant importance. However, I felt there may be difficulties in creating a measure which adequately accounted for the differing experiences, challenges and demands faced by both qualified and unqualified psychological practitioners. Experiences that might be more applicable to

147

unqualified psychological practitioners and that could play a role in workplace wellbeing include, academic demands, application to training demands and differing clinical responsibilities.

Similarly, it was decided that the PPWWM would be developed for use with individuals working in an organisation and not solely in private practice. Although there are undoubtably challenges associated with working solely in private practice, when reviewing the wellbeing constructs identified in Phase 1 of the measure development: the qualitative identification of constructs of psychological practitioner general wellbeing, it was noted that a significant proportion of the identified constructs would not be applicable to those working solely in private practice. These included, organisational targets, organisational pressure, personal support from colleagues and personal support from professional manager.

Sample Size and Power Analysis

It is important to consider that a limitation of this study is the small participant samples within some of the early stages of the measure development. However, considering there were multiple stages involved in creating the measure and the total participant number for the five development stages was n=79, it is hoped this would not reduce the utility of the measure.

An assessment of statistical power using G*Power (Faul, Erdfelder, Lang & Buchner, 2007) was conducted prior to beginning the research, to identify the required sample size for the correlations conducted as part of the validation of the PPWWM. G*Power estimated a minimum sample size of 153 participants was required to detect a small correlation of 0.2, at a

power of 0.8. In total, 479 responses were obtained in the main study. However, 67 of these

responses were incomplete and 10 responses were removed as a result of participants not

meeting the inclusion criteria, most frequently due to not being a qualified psychological

practitioner. Additionally, it was decided that any individual who had provided the same

response to ≥ 90% of items would be removed from analysis. This was to ensure the survey had

been completed appropriately and participants had not provided the same answer to each

item. Subsequently, following a full assessment of the data, two additional participant

responses were removed. The achieved power with the final sample size (n= 400), to detect a

small correlation of .2 with alpha set at .05, was .99. Similarly, to detect a very small correlation

of .1, the achieved power was 0.64 (Faul et al., 2007).

Although the achieved power was high because of the large sample size, 400

participants is a very small percentage of the individuals who would have been eligible to

participate in this research and who would have received an invitation for participation.

Additionally, some of the early stages of the measure development had small participant

sample sizes. Furthermore, the avenue through which individuals received invitations to

participate was not recorded. Therefore, it is not possible to determine whether there is any

bias based on participants who are registered with a professional group. Future research

should further assess the validity of the measure with larger and more diverse samples and

consider the representativeness of the studied samples.

Another implication of the very high power of the survey validation study is that small

significant correlations were detected. While these were *statistically* significant, they depicted

very small degrees of relationship that may not be practically or clinically useful with smaller participant samples.

Measures

The demographic questionnaire used to collect participant information included: profession, type of contract, years since professional qualification, years worked since professional qualification, years employed in current post, contracted hours, type of employer organisation, pay scale, gender, illness and disability and age. Future research should also consider participant ethnicity, geographical location, client group (e.g. adult mental health, child and adolescent, older adult), years in current post and workplace activities (e.g. quantity of clinical work, supervision, managerial responsibilities) to ensure cross-validation and the applicability of the PPWWM for use with all psychological practitioners.

The measures selected for dissemination alongside the PPWWM, to assess construct validity of the new measures, were the Health and Safety Executive Management Standards Indicator Tool (HSEMS-IT; HSE, 2004), the Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen & Griffin, 1985) and the General Health Questionnaire (GHQ-12; Goldberg, 1992).

The HSEMS-IT (HSE, 2004) is a 35-item measure, with low scores indicating high levels of work-related stressors. The measure has demonstrated high internal consistency and reliability and has been found to contain a seven-factor structure relating to the six key areas of work-related stressors identified in the Health and Safety Management Standards (Cousins et al.,

2004). The measure has been used extensively including with large samples of NHS employees. This measure was chosen as it was expected there would be a strong positive correlation between HSEMS-IT score and PPWWM score considering both measures aim to assess aspects relating to work design and workplace experiences.

The SWLS (Diener et al., 1985) is a five-item measure which has also demonstrated high internal consistency, reliability and temporal stability. It has been found to have one factor relating to an individual's global evaluative judgement of their satisfaction with life according to their own criteria. This measure was used because of its brevity and it was expected there would be a positive correlation between overall life satisfaction and workplace wellbeing. However, this association was likely to be lower than that between HSEMS-IT (HSE, 2004) and the PPWWM, considering factors other than experiences within the workplace are related to overall satisfaction with life.

The GHQ-12 (Goldberg, 1992) is a shortened version of the original 60-item GHQ (Goldberg, 1978). High scores on the GHQ indicate poorer mental health. The GHQ measures require a license for use, which the University had previously obtained within a battery of assessments. The 12-item GHQ (Goldberg, 1992) and 28-item GHQ (Goldberg, 1978) are regularly used to assess distress linked to occupational stressors. In a systematic review, Goodwin et al. (2013) reported 65 studies which utilised the GHQ-12 or GHQ-28 for this purpose. Considering the number of items contained within the main study, to reduce the length of the overall survey it was decided to use the GHQ-12 (Goldberg, 1992) as this is a 12-item measure. The GHQ-12 is one of the most frequently used measures to assess symptoms of

common mental disorder in the UK (Goodwin et al., 2013) and has demonstrated high internal consistency, test-retest reliability and construct validity. The measure has been validated to assess psychological morbidity in clinical and non-clinical samples and within samples of NHS employees. It was predicted there would be a negative correlation between GHQ-12 score and PPWWM: poorer mental health associated with lower workplace wellbeing.

During stage 1 (item development) and stage 2 (item review) of the measure development, negatively and positively keyed items were included. During later stages of the development it appeared that the negatively keyed items were generally deemed less suitable for inclusion and the final PPWWM contained 26 items: 21 positively keyed and 5 negatively keyed. While negatively keyed items, also referred to as reversed items, are often included in measures to prevent acquiescence bias, it has also been suggested they are ineffective in doing so (van Sonderen, Sanderman & Coyne, 2013). Additionally, from a psychometric perspective, reversed items can be confusing to respondents, particularly in longer questionnaires (DeVellis, 2017) and it has been proposed that they can produce factor structure problems (Woods, 2006). Therefore, future research should conduct further item analysis to specifically review the negatively keyed items within the PPWWM.

Data Analysis

To ensure appropriate methods of data analysis were used to review participant responses in stage 3 (construct review) and stage 4 (ranking of item relevance for inclusion) of the survey development, I met with a University statistician. It was suggested that no formal

statistical analysis was required or appropriate for these stages of the survey development, and the proposed methods of analysis would suffice.

In the main study, a visual inspection of the histogram detailing the distribution of PPWWM scores appeared well distributed. However, the testing of normality established the PPWWM data were non-normal. This was likely to be a result of the high statistical power provided by the sample size to detect small effects. Therefore, a bootstrapping module in SPSS was used for correlation and analysis of variance tests. Bootstrapping (Efron & Tibshirani, 1993) involves estimating the properties of the sampling distribution from the sample data and produces percentile bootstrap confidence intervals based on the values between which 95% or 99% (depending on Alpha) of bootstrap sample estimates fall (Field, 2018).

To examine the test-retest reliability of the PPWWM, data from Time 1 of completion was manually matched with data from Time 2. A strong positive correlation was observed between score at Time 1 and score at Time 2. However, statistical analysis indicated the mean scores were significantly different. This difference was probably a result of the high power of the sample, and a very small effect size was observed: d = .078. A significant difference between scores at Time 1 and Time 2 could have been seen due to practice effects: familiarity with the measure may have caused participants to respond differently at Time 2. Future research should consider replication of the assessment of temporal stability of the PPWWM.

To explore any variation in PPWWM scores explained by participant demographic information, tests to assess Eta (η), F-ratios and Kendall's Tau-b (τ_b) were conducted, depending on the nature of the data (nominal, interval or ordinal). A Bonferroni adjustment was required

to reduce the likelihood of Type 1 errors, due to multiple comparisons. A Type 1 error occurs when it is believed there is a genuine effect in the population, and there is not. Assuming a test uses a 0.05 level of significance, the chances of making a Type 1 error are 5% and therefore the chances of not making a Type 1 error are 95%. However, when conducting 12 tests, the probability of not making a Type 1 error is: $0.95^{12} = 0.54$ or 54%. Therefore, the likelihood of at least one error when conducting 12 tests is 0.46 or 46%. This is known as the familywise or experimentwise error rate (Field, 2018).

However, Bonferroni corrections are highly conservative, and it has been proposed they can fail to identify significant relationships (Bland & Altman, 1996). This could be seen as a significant limitation of the results analysing the associations between the PPWWM scores and demographic variables and consequently the findings before Bonferroni correction were also considered within the paper.

Future Research

Suggestions for future research are fully reviewed within the empirical paper and have been discussed in previous sections within this paper. It is suggested that future research should consider further validation of the measure with a wider range of professional groups, the comparison of the measure across different UK countries and within different professional settings. Furthermore, considering a small number of items loaded on to some factors within the PPWWM exploratory factor analysis, confirmatory factor analysis should assess the strength of the proposed factor solution with an independent sample. This analysis could be

conducted using the data obtained in the 2017 NSP and DCP annual workforce wellbeing survey.

On completion of the Doctorate of Clinical Psychology, in addition to publishing this research, I plan to conduct a confirmatory factor analysis on the HSEMS-IT (HSE, 2004) using the data collected in the main study of the measure development and utilise the results from the NSP and DCP 2017 annual wellbeing survey to conduct a confirmatory factor analysis on the PPWWM.

Implications of Research

Despite the recognition of the importance of health-care professionals' wellbeing and the implementation of policies and frameworks guidelines, a gap remains between translating the intentions into a reality of improved staff wellbeing. The 2016 results of the NSP and DCP annual workforce wellbeing survey showed that of the 1227 respondents, 48% of psychological practitioners indicated they had felt depressed 'some of the time' or more frequently over the previous week, 46% indicated they had felt like a failure 'some of the time' or more frequently over the previous week and 92% indicated they found their job stressful 'some of the time' or more frequently (Dosanjh & Bhutani, 2017).

In 2009, the National Institute for Health and Care Excellence (NICE, 2009) introduced guidance on wellbeing at work as part of a wider government-sponsored approach to promote positive workplace interventions. These guidelines suggest mental wellbeing at work should be monitored (NICE, 2009). However, in 2010, the Health and Work Development Unit conducted

a national audit (Royal College of Physicians, 2011) to assess how well NHS Trusts in England were progressing with the implementation of a range of recently published NICE guidelines relating to health and wellbeing within the workplace, including the publication "Mental Wellbeing at Work" (NICE, 2009). Following this, a second, repeat audit was conducted in 2013 (Sloan et al., 2014). In round two, 204 Trusts registered to take part (73% of all NHS England Trusts). Results indicated only 57% of Trusts had an organisation wide plan or policy for mental wellbeing, a modest increase on the 48% that was recorded in round one of the audit in 2010. Furthermore, 76% of the Trusts (136 Trusts) reported to have systems in place to monitor the mental wellbeing of staff, suggesting 24% of the Trusts did not. To my knowledge this audit has not been conducted again since round two.

Healthcare professional wellbeing should be a priority and both individual and system level strategies should be implemented to support practitioner psychologist workplace wellbeing (Rao et al., n.d.). The PPWWM has been shown to have favourable psychometric qualities and provides a useful tool for both practitioners and researchers to monitor and assess workplace wellbeing. However, in my opinion, as with all psychometric measures, it is important to also consider individual qualitative experiences and the measure should not be used in isolation. While the PPWWM may provide an overview or general impression of workplace wellbeing within organisations or professional groups, the measure could also be used as a tool to initiate conversations about workplace wellbeing, for example within clinical supervision.

It is important to note that many of the clinical implications (discussed above) relating to the findings from the systematic review are also relevant to this study.

Personal and Professional Reflections

Completing this research has been both challenging and rewarding. It has been a privilege to have been involved in the NSP and DCP wellbeing project and to have conducted research which has received a high level of interest and enthusiasm from many clinicians. Furthermore, through conducting this research, I have built positive working relationships with other professionals within the NSP and DCP collaborative working group. I have also actively sought additional opportunities to be involved in the work of this professional group, in addition to the survey development project. For example, most recently, I led the design of the 2017 NSP and DCP annual workforce wellbeing survey and contributed to data management.

Whilst conducting this research, I have valued the conversations I have had with a range of different healthcare professionals regarding employee wellbeing. I have noticed that, given an opportunity, it is common for individuals to openly share their personal experiences relating to wellbeing at work. While it is a professional expectation that psychological practitioners engage in clinical supervision, there are not such formal processes in existence within many other professional groups. I have been interested that, when given an opportunity and through the provision of a safe space to reflect, many professionals appear to value the process of talking about their personal experiences regarding wellbeing at work and factors which influence this. As a trainee clinical psychologist, this has developed my skills in providing consultation and a reflective space for other professionals, both relating directly to clinical work, and in relation to the impact of work-place experiences on clinical practice.

Where possible, it is best practice for practitioner psychologists to work collaboratively with Experts by Experience (BPS, 2017). While conducting this research I have engaged in informal conversations regarding the research aims, with an acquaintance and colleague who is an Expert by Experience and an active member of many committees. Discussions were largely concerned with how, if at all, the opinion of Experts by Experience could inform the PPWWM development. Considering this measure was specifically designed for use with psychological practitioners, it was difficult to establish a way of involvement. However, these conversations supported my lines of enquiry when considering a systematic review question.

Developing a new quantitative measure has lead me to take an increased interest in how existing psychometric measures have been developed and their validity and reliability for use within certain populations. I feel this has enabled me to make more informed decisions about the psychometric outcome measures I use within my clinical practice as a trainee clinical psychologist. Furthermore, through conducting this research, I have developed a general interest in the use of psychometric measures and the strengths and weakness of their use. I have reflected on the reductionist nature of psychometric measures and the importance of also observing an individual's personal experiences. However, I have also observed the value of obtaining broad quantitative information, through the use of psychometric measures, relating to specific professional groups, services, organisations. I feel this reflects the nature of a clinical psychologist's role; the ability to adapt and adjust practice at different times, based on patient, service and organisational need.

Research Dissemination

Dissemination of this research to professionals and academics will be targeted through submission to academic journals. I have prepared paper 1 for submission to the Journal of Clinical Psychology and Psychotherapy (impact factor: 1.933, ISI Journal Citation Reports © 2016 Ranking 56/121: Psychology, Clinical). Paper 2 has been prepared for submission to the Journal of Occupational and Organisational Psychology (impact factor: 3.139, ISI Journal Citation Reports © 2016 Ranking: 38/194; Management, 9/80; Psychology, Applied).

Beyond publication in peer-reviewed journals, the PPWWM was used within the 2017 NSP and DCP annual workforce wellbeing survey which was disseminated in December 2017. In January 2018, I presented the empirical study at the British Psychological Society DCP Annual Conference, within the DCP Leadership and Management Faculty Stream, alongside members of the NSP and DCP collaborative network. Following this, I was invited to present at the New Savoy Conference (NSC) in March 2108. At the NSC, I co-facilitated a keynote session alongside members of the NSP and DCP Collaborative Learning Network, titled: 'Are we generating a culture of less psychological safety for our staff? Results of the annual NSP/BPS Psychological Staff Wellbeing Survey'. In addition to this, I facilitated a workshop based solely on the development of the PPWWM and co-facilitated a workshop titled: 'Making a safe space for your staff team to talk about what matters'.

More recently, I submitted a short article to the DCP Wales Newsletter for publication in June 2018. During the development of the measure, I was also contacted by 14 clinicians, some providing feedback on the measure development and others offering personal and professional

reflections on the importance of workplace wellbeing for psychological practitioners. A number

of these clinicians also requested information regarding publication of this research and

requested use of the new measure. The PPWWM has been shared with these individuals,

pending submission to a peer reviewed journal. I am also currently in discussion with my

supervisors regarding how to ensure this measure is freely available for use on a public

platform.

References

Adriaenssens, J., De Gucht, V., & Maes, S. (2015). Determinants and prevalence of burnout in

emergency nurses: A systematic review of 25 years of research. *International Journal of*

Nursing Studies, *52*, 649-661. doi: 10.1016/j.ijnurstu.2014.11.004

Almarshad, S. O. (2015). A measurement scale for evaluating quality of work life:

Conceptualization and empirical validation. *Trends in Applied Sciences Research*, *10*(3),

143. doi: 10.3923/tasr.2015.143.156

Barnett, J. E., & Cooper, N. (2009). Creating a culture of self-care. *Clinical Psychology: Science*

and Practice, 16, 16–20. doi: 10.1111/j.1468-2850.2009.01138.x

Brand, S. L., Coon, J. T., Fleming, L. E., Carroll, L., Bethel, A., & Wyatt, K. (2017). Whole-system

approaches to improving the health and wellbeing of healthcare workers: A systematic

review. *PloS one, 12*(12), 1-26. doi: 10.1371/journal.pone.0188418

Brooks BA. (2001). *Development of an instrument to measure quality of nursing worklife*

(Unpublished doctoral dissertation). University of Illinois at Chicago.

Centre for Reviews and Dissemination. (2009). *Systematic reviews: CRD's guidance for*

undertaking reviews in health care. Retrieved from

https://www.york.ac.uk/media/crd/Systematic_Reviews.pdf

Cousins, R., Mackay, C. J., Clarke, S. D., Kelly, C., Kelly, P. J., & McCaig, R. H. (2004).

'Management standards' work-related stress in the UK: Practical development. *Work &*

Stress, *18*(2), 113-136. doi: 10.1080/02678370410001734322

Bland, J. M. & Altman, D. G. (1996). Measurement error. *British Medical Journal,* 313, 744.

      1654. doi: https://doi.org/10.1136/bmj.313.7059.744

British Psychological Society (2008). *Professional Practice Board: Generic Professional Practice*

      Guidelines, 2nd Ed., Leicester: British Psychological Society.

British Psychological Society (2010). *The core purpose and philosophy of the profession.*

      Leicester: British Psychological Society.

British Psychological Society (2014). *DCP Policy on Supervision.* Leicester: British Psychological

      Society.

British Psychological Society (2015). *Clinical psychology in Britain: Historical perspectives*.

      Leicester: British Psychological Society.

British Psychological Society (2017). *Practice Guidelines, 3rd ed.* Leicester: British Psychological

      Society.

Charrois, T. L. (2015). Systematic Reviews: What do you need to know to get started? *The*

      Canadian Journal of Hospital Pharmacy, 68(2), 144-148.

Chew-Graham, C. A., Rogers, A., & Yassin, N. (2003). 'I wouldn't want it on my CV or their

      records': medical students' experiences of help-seeking for mental health

      problems. *Medical education*, *37*(10), 873-880. doi: 10.1046/j.1365-2923.2003.01627.x

Department of Health (1993). *A vision for the future. Report of the Chief Nursing Officer.*

      London: DoH.

DeVellis, R. F. (2017). *Scale development: Theory and applications* (4th ed.). Los Angeles: Sage

      Publications.

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment, 49*, 71–75. doi: 10.1207/s15327752jpa4901_13

Dimotakis, N., Scott, B. A., & Koopman, J. (2011). An experience sampling investigation of workplace interactions, affective states, and employee well-being. Journal of Organizational Behavior, 32(4), 572–588. doi: 10.1002/job.722

Dorociak, K. E., Rupert, P. A., & Zahniser, E. (2017). Work life, well-being, and self-care across the professional lifespan of psychologists. *Professional Psychology: Research and Practice*, *48*(6), 429-437. doi: 10.1037/pro0000160

Dosanjh, N. & Bhutani, G. (2017, March). Workforce Wellbeing Survey 2014-2016. Workshop presented at the New Savoy Conference 2017: Psychological Therapies in the NHS, London.

Dwan, K., Altman, D. G., Arnaiz, J. A., Bloom, J., Chan, A.-W., Cronin, E., …Williamson, P. R. (2008). Systematic review of the empirical evidence of study publication bias and outcome reporting bias. *PLoS ONE, 3*(8). doi:10.1371/journal.pone.0003081

Edmondson, A. C. (1999). Psychological safety and learning behavior in work teams*. Administrative Science Quarterly, 44,* 350–383. doi: 0001 -8392/99/4402-0350

Efron, B. & Tibshirani, R. (1993). *An Introduction to the Bootstrap, Monographs on Statistics and Applied Probability*. New York: Chapman & Hall.

Egger, M., Juni, P., Bartlett, C., Holenstein, F., & Sterne, J. (2003). How important are comprehensive literature searches and the assessment of trial quality in systematic

reviews? Empirical study. *Health Technology Assess, 7*(1), 1-76. Retrieved from

https://pdfs.semanticscholar.org/18da/e5c7d340138dba23fcfe35754b09d1dd89c8.pdf

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G* Power 3: A flexible statistical power

analysis program for the social, behavioral, and biomedical sciences. *Behavior research

methods*, *39*(2), 175-191. Retrieved from

https://link.springer.com/content/pdf/10.3758%2FBF03193146.pdf

Field, A. (2018). *Discovering statistics using IBM SPSS Statistics* (5th ed.) London: Sage

Publications.

Greenhalgh, J., & Brown, T. (2014). Quality assessment: Where do I begin? In A. Boland, M. G.

Cherry, R. & Dickson, (Eds.), *Doing a systematic review: A Students Guide* (pp. 61-83).

London: SAGE Publications Ltd.

Goodwin, L., Ben-Zion, I., Fear, N. T., Hotopf, M., Stansfeld, S. A., & Wessely, S. (2013). Are

reports of psychological stress higher in occupational studies? A systematic review

across occupational and population based studies. *PLoS One*, *8*(11), 1-22. doi:

10.1371/journal.pone.0078693

Goldberg, D. (1978). *General Health Questionnaire (GHQ-60).* Windsor: NFER-NELSON

Goldberg, D. (1992). *General Health Questionnaire (GHQ-12).* Windsor: NFER-NELSON

Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare staff wellbeing,

burnout, and patient safety: a systematic review. *PLoS One*, *11*(7), 1-12. doi:

10.1371/journal.pone.0159015

Health and Safety Executive (HSE). (2004). *Management Standards Indicator Tool.* Retrieved

from www.hse.gov.uk/stress/ standards/pdfs/indicatortool.pdf

Hannigan, B., Edwards, D., & Burnard, P. (2004). Stress and stress management in clinical

psychology: Findings from a systematic review. *Journal of Mental Health*, *13*(3), 235-

245. doi: 10.1080/09638230410001700871

Jarde, A., Losilla, J. M., & Vives, J. (2012). Methodological quality assessment tools of non-

experimental studies: a systematic review. *Anales de Psicología, 28*(2), 617-628.

doi: 10.6018/analesps.28.2.148911

Jones, C. & Summers, E.M.A. (2013, December). *Surviving on the front line: The importance of*

psychological support in the Emergency Department. Poster presented at the Division of

Clinical Psychology Annual Conference: Taking Care, Giving Care, York.

Karasek, R. A., & Theorell T. (1990). *Healthy work: Stress, productivity, and the reconstruction of*

working life. New York: Basic Books.

Maslach, C., & Jackson, S.E. (1986). *Maslach burnout inventory manual* (2nd ed.). Palo Alto,

California: Consulting Psychologists Press.

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of*

Organizational Behavior, *2*, 99-113. doi: 10.1002/job.4030020205

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for

systematic reviews and meta-analyses: the PRISMA statement. *International journal of*

surgery, *8*(5), 336-341. doi: 10.1371/journal.pmed.1000097

Munsey, C. (2006). Questions of balance: An APA survey finds a lack of attention to self-care among training programs. *GradPSYCH,* 4.

National Institute for Health and Clinical Excellence. (2009). *Mental wellbeing at work* (Public Health Guideline ph22). London. NICE.

New Savoy Partnership (n.d.). *NSP/BPS Staff Wellbeing Charter.* Retrieved from https://www.newsavoypartnership.org/nsp-bps-staff-wellbeing-charter.htm

Norcross, J. C., & Guy, J. D., Jr. (2007). *Leaving it at the office: A guide to psychotherapist self-care.* New York: Guilford Press.

Rao, A., Bhutani, G., Clarke, J., Dosanjh, N., & Parhar, S. (n.d.). The case for a charter for psychological wellbeing and resilience in the NHS. Retrieved from https://www1.bps.org.uk/system/files/user-files/DCP%20Leadership%20and%20Management%20Faculty/public/final_draft_case_for_a_charter_for_psychological_wellbeing_and_resilience_copy.pdf

Royal College of Physicians (2011). *Implementing NICE public health guidance for the workplace: A national organisational Audit of NHS trusts in England.* London: Royal College of Physicians.

Rt. Hon. Burt, A. (2016). NSP/BPS Staff Wellbeing Charter. Retrieved from https://www.newsavoypartnership.org/nsp-bps-staff-wellbeing-charter.htm

Sanderson, S., Tatt, I.D., & Higgins, J.P.T. (2007). Tools for assessing quality and susceptibility to bias in observational studies in epidemiology: a systematic review and annotated

bibliography. *International Journal of Epidemiology, 36*, 666-676.

doi:10.1093/ije/dym018

Schaufeli, W. B., & Van Dierendonck, D. (1995). A cautionary note about the cross-national and

clinical validity of cut-off points for the Maslach Burnout Inventory. *Psychological*

reports, *76*, 1083-1090. doi: 10.2466/pr0.1995.76.3c.1083

Sloan, D., Jones, S., Evans, E., Chant, L., Williams, S. & Peel, P. (2014). Implementing NICE public

health guidance for the workplace: A national organisational Audit of NHS trusts in

England: Round 2. London: Royal College of Physicians.

Smith, P. L., & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented,

and what can be done to address it? Clinical Psychology: Science and Practice, 16, 1–15.

doi: 10.1111/j.1468-2850.2009.01137.x

The Joanna Briggs Institute. (2016). *The Joanna Briggs Institute critical appraisal tools for use in*

JBI systematic reviews: Checklist for prevalence studies. Retrieved from

http://joannabriggs.org/research/critical-appraisal-tools.html

The Joanna Briggs Institute. (2017). *Joanna Briggs Institute Reviewer's Manual*. Retrieved from

https://reviewersmanual.joannabriggs.org/

Trethowan, W. H. (1977). *The role of psychologists in the health services: report of the sub-*

committee. London: HMSO.

Van Laar, D., Edwards, J. A., & Easton, S. (2007). The Work-Related Quality of Life Scale for

healthcare workers. *Journal of advanced nursing*, *60*(3), 325-333. doi: 10.1111/j.1365-

2648.2007.04409.x

Van Sonderen, E., Sanderman, R., & Coyne, J. C. (2013). Ineffectiveness of reverse wording of

questionnaire items: Let's learn from cows in the rain. *PloS one*, *8*(7), 1-7. doi:

10.1371/journal.pone.0068967

Walsh, S., & Cormack, M. (1994). 'Do as we say but not as we do': Organizational, professional

and personal barriers to the receipt of support at work. *Clinical Psychology &*

Psychotherapy, 1(2), 101-110. doi: 1063-3995/94/020101-10

Ware, M. (2008). Peer review in scholarly journals: Perspective of the scholarly community–

Results from an international study. *Information Services & Use*, *28*(2), 109-112. doi:

10.3233/ISU-2008-0568

Woods, C. M. (2006). Careless responding to reverse-worded items: Implications for

confirmatory factor analysis. *Journal of Psychopathology and Behavioral*

Assessment, *28*(3), 186-191. doi: 10.1007/s10862-005-9004-7

Wright, A. (2012). *Predictions on the future of clinical psychology in Wales: A modified Delphi*

study (Unpublished doctoral dissertation). Retrieved from Orca, Cardiff University,

Cardiff.

Appendices

Appendix A

Clinical Psychology & Psychotherapy Author Guidelines

Clinical Psychology & Psychotherapy

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a meeting or symposium.

Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at http://mc.manuscriptcentral.com/cpp.

The submission system will prompt you to use an ORCiD (a unique author identifier) to help distinguish your work from that of other researchers. Click here to find out more.

Click here for more details on how to use ScholarOne Manuscripts.

For help with submissions, please contact the Editorial Office at CPPedoffice@wiley.com

Clinical Psychology & Psychotherapy aims to keep clinical psychologists and psychotherapists up to date with new developments in their fields. The Journal will provide an integrative impetus both between theory and practice and between different orientations within clinical psychology and psychotherapy. *Clinical Psychology & Psychotherapy* will be a forum in which practitioners can present their wealth of expertise and innovations in order to make these available to a wider audience. Equally, the Journal will contain reports from researchers who want to address a larger clinical audience with clinically relevant issues and clinically valid research. The journal

is primarily focused on clinical studies of clinical populations and therefore no longer normally accepts student-based studies.

This is a journal for those who want to inform and be informed about the challenging field of clinical psychology and psychotherapy.

Submissions which fall outside of Aims and Scope, are not clinically relevant and/or are based on studies of student populations will not be considered for publication and will be returned to the author.

2. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Research articles: Substantial articles making a significant theoretical or empirical contribution.

Reviews: Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies.

Assessments: Articles reporting useful information and data about new or existing measures.

Practitioner Reports: Shorter articles (a maximum of 1200 words) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e. be innovative).

3. PREPARING THE SUBMISSION

Parts of the Manuscript
The manuscript should be submitted in separate files: title page; main text file; figures.

File types

Preferred formats for the text and tables of your manuscript are .doc, .docx, .rtf, .ppt, .xls. LaTeX files may be submitted provided that an .eps or .pdf file is provided in addition to the source files. Figures may be provided in .tiff or .eps format.

New Manuscript
Non-LaTeX users: Upload your manuscript files. At this stage, further source files do not need to be uploaded.
LaTeX users: For reviewing purposes you should upload a single .pdf that you have generated from your source files. You must use the File Designation "Main Document" from the dropdown box.

Revised Manuscript

Non-LaTeX users: Editable source files must be uploaded at this stage. Tables must be on separate pages after the reference list, and not be incorporated into the main text. Figures should be uploaded as separate figure files.
LaTeX users: When submitting your revision you must still upload a single .pdf that you have

generated from your revised source files. You must use the File Designation "Main Document" from the dropdown box. In addition you must upload your TeX source files. For all your source files you must use the File Designation "Supplemental Material not for review". Previous versions of uploaded documents must be deleted. If your manuscript is accepted for publication we will use the files you upload to typeset your article within a totally digital workflow.

The text file should be presented in the following order:

1. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);

2. A short running title of less than 40 characters;

3. The full names of the authors;

4. The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;

5. Conflict of Interest statement;

6. Acknowledgments;

7. Abstract, Key Practitioner Message and keywords;

8. Main text;

9. References;

10. Tables (each table complete with title and footnotes);

11. Figure legends;

Figures and appendices and other supporting information should be supplied as separate files.

Authorship
Please refer to the journal's Authorship policy in the Editorial Policies and Ethical Considerations section below for details on author listing eligibility.

Acknowledgments
Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned, including the name(s) of any sponsor(s) of the research contained in the paper, along with grant number(s). Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement
Authors will be asked to provide a conflict of interest statement during the submission process.

For details on what to include in this section, see the <u>Conflict of Interest</u> section in the Editorial Policies and Ethical Considerations section below. Submitting authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Abstract

Enter an abstract of no more than 250 words containing the major keywords. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.

Key Practitioner Message All articles should include a Key Practitioner Message of 3-5 bullet points summarizing the relevance of the article to practice.

Keywords

Please provide five-six keywords (see <u>Wiley's best practice SEO tips</u>).

Main Text

1. The journal uses US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

2. Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

References

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in-text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

For more information about APA referencing style, please refer to the <u>APA FAQ</u>.

Endnotes

Endnotes should be placed as a list at the end of the paper only, not at the foot of each page. They should be numbered in the list and referred to in the text with consecutive, superscript Arabic numerals. Keep endnotes brief; they should contain only short comments tangential to the main argument of the paper.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §,

¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted. Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Figures submitted in color may be reproduced in color online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. The cost of printing color illustrations in the journal will be charged to the author. The cost is £150 for the first figure and £50 for each figure thereafter. If color illustrations are supplied electronically in either TIFF or EPS format, they may be used in the PDF of the article at no cost to the author, even if this illustration was printed in black and white in the journal. The PDF will appear on the Wiley Online Library site.

Additional Files

Appendices

Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

General Style Points

The following points provide general advice on formatting and style.

1. **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.

2. **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.

3. **Numbers:** numbers under 10 are spelled out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

4. **Trade Names:** Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If

proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.

Appendix B

Example of Database Search Terms: PsycINFO Search

1	"clinical psychologist*".ti,ab.	6064
2	"counsel* psychologist*".ti,ab.	1998
3	psychologist*.ti,ab.	81114
4	"psychological practitioner*".mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	111
5	"practitioner psychologist*".mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	43
6	"registered psychologist*".mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	57
7	"forensic psychologist*".mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	760
8	"health psychologist*".mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	718
9	"occupational psychologist*".mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]	69
10	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9	81225
11	burnout.ti,ab.	5741
12	"burn out".ti,ab.	117
13	"burn* out".ti,ab.	180
14	stress.ti.	66549
15	11 or 12 or 13 or 14	71649
16	10 and 15	768

Appendix C

Quality Assessment Tool

Yes/fully addressed (2): Criterion deemed to be fully addressed and clearly reported.

Partial/unclear (1): Criterion deemed to be partially addressed and reported. If addressed, the factor was deemed to be unclear or lacking in sufficient detail.

No/not addressed/not applicable (0): Criterion deemed to be insufficiently addressed, or poorly addressed, or the factor was not applicable for this study.

Q	Criteria	Yes/fully addressed (2)	Partial/unclear (1)	Not addressed/poor/not applicable (0)
	Research Design			
1	Research aims and hypotheses	Study aims are clearly specified. Hypotheses clearly defined.	Study aims and/or hypotheses briefly defined or unclear.	Study aim and hypotheses not specified/not addressed.
	Sampling/population			
2	Representative sample	Representation of the sample was clearly reported and defined. Study population is representative of potential study population e.g. balance of gender, age etc.	Representation of the sample was partially reported or defined but unclear/participants were partially representative of potential study population e.g. balance of gender, age etc.	Representation of the sample was not addressed/subjects not representative of potential study population e.g. insufficient balance of gender/age etc.

3	Criteria for inclusion and exclusion	Inclusion and exclusion criteria definitively outlined.	Inclusion and exclusion criteria partially outlined/unclear.	Inclusion and exclusion criteria not outlined.
4	Recruitment	Study recruitment fully explained.	Study recruitment unclear/partially explained.	Study recruitment not explained.
5	Sample size	Sample size was addressed and justification for sample size provided.	The sample size was partially addressed. Partial/unclear justification was given.	No explanation or/justification for sample size given.
6	Response rate	Response rate was reported with comments addressing rate e.g. compared to other similar studies.	Response rate was reported but not commented on.	Response rate was not reported.
	Measurement			
7	Validity of measures	Study used previously validated assessment measures. Choice of measure was justified with reference to previous research.	Study used combination of validated and unvalidated measures OR choice of measure was not justified/unclear.	Study used unvalidated measures and choice unjustified.
	Analysis			
8	Missing data	Any missing data was reported/explained. If missing data was reported, explanations of what was done were given e.g. removal/compensatory measures conducted.	Missing data was reported/ explained, but no explanation of management of missing data was given/management of missing data was unclear	Missing data was not addressed.
9	Statistical analysis and results	Participant demographic information clearly reported and described e.g. age, gender, years in service etc. Statistical analysis used to analyse data	Participant demographic information partially described or unclear. OR Statistical analysis used was unclear/ partially explained.	Statistical analysis not fully explained or described. OR some analysis did not sufficiently address study design. Correlations were not

		were clearly explained and described. Analysis was appropriate to address the aims/ test the hypotheses e.g. considering confounding variables. Correlations were included to investigate variables impacting on stress/burnout. Sufficient information was included to enable replication.	OR analysis partially addressed aims or hypotheses. OR correlations were included to investigate some variables impacting on stress/burnout. OR further information would be required for replication.	included. OR no information enabling replication.
	Discussion of findings			
10	Conclusions	Conclusions were drawn to accurately reflect analysis, considering any limitations e.g. sample size, methodology etc. Generalisability was discussed in relation to outcomes.	Conclusions or generalisability were over-stated/understated/ inaccurate/unclear when considering any limitations e.g. sample size, methodology etc.	Conclusions or generalisability not in-line with research findings or method. Limitations were poorly addressed or not mentioned.
11	Future research	Suggestions for future research were addressed.	Suggestions for future research were partially addressed/implied/unclear.	Suggestions for future research were not addressed.

Reviewer ………………………………………… Date……………………………………………

Paper title………………………………………………………………………………… Author
(s)……………………………………………………………………………

Q	Criteria	Yes/fully addressed (2)	Partial/unclear (1)	No/not addressed/not applicable (0)
	Research Design			
1	Research aims and hypotheses			
	Sampling/population			
2	Representative sample			
3	Criteria for inclusion and exclusion			
4	Recruitment			
5	Sample size			
	Response rate			
6	**Measurement**			
	Validity of measures			
7	**Analysis**			
8	Missing data			
	Statistical analysis and results			
9	**Discussion of findings**			
10	Conclusions			
11	Future research			

Appendix D

Journal of Occupational and Organizational Psychology Author Guidelines

Author Guidelines

The Journal of Occupational and Organizational Psychology publishes empirical and conceptual papers which aim to increase understanding of people and organizations at work. Its domain is broad, covering industrial, organizational, engineering, vocational and personnel psychology, as well as behavioural and cognitive aspects of industrial relations, ergonomics, human factors and industrial sociology. Innovative or interdisciplinary approaches with a psychological emphasis are particularly welcome. So are papers which develop the links between occupational/organizational psychology and other areas of the discipline, such as social and cognitive psychology.

We welcome the following varieties of paper:

• empirical research papers, containing new quantitative or qualitative data which address significant theoretical and/or practical concerns;

• papers which offer new theory and conceptualisation, perhaps accompanied by a critique of existing approaches;

• narrative and/or quantitative reviews of existing research which lead to new conclusions or insights into a field of research and/or practice;

• prescriptive articles advocating changes in research paradigms, methods, or data analytic techniques;

• analyses of practice in occupational and organizational psychology, where such analyses are driven by theory and/or sound data.

All papers published in The Journal of Occupational and Organizational Psychology are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

The word limit for papers submitted for consideration to JOOP is 8000 words and any papers that are over this word limit will be returned to the authors. The word limit does not include abstract, references, figures, and tables. Appendices however are included in the word limit. The Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length (e.g., a new theory or a new method). The authors should contact the Editor first in such a case.

In order to supplement innovative research produced in full paper format, the journal provides access to a wider range of investigation through the publication of research in Short Research Note format. Papers submitted as Short Research Notes will be subject to the normal double-blind review process. Short Research Notes should be largely empirical studies. Typically, they will do one of the following:

• replicate existing findings in a new context;
• develop new measures and report on their reliability and validity;
• report contradictory findings that sharpen the interpretation of existing research;
• present new applications of an existing measure;
• report descriptive findings or case studies that will significantly develop professional practice;
• offer an informed and focused challenge to key elements of an existing study, theory or measure.

Papers submitted as Short Research Notes should not exceed 2000 words, including the abstract but not including references or tables. It is normally expected that any tables will take up no more than two printed pages, and there should be no more than about 15 references. With the exception of the items of a new or substantially revised measure, appendices are discouraged.

A paper submitted as a Short Research Note will not necessarily receive positive reviews simply because it falls into one of the categories listed above. Papers need to be located in a conceptual/theoretical context, with rigorous method and appropriate reporting. The issues they raise and/or the findings they report must be deemed to be contributing significantly to the knowledge and understanding of academics and/or practitioners in occupational and organizational psychology. Short Research Notes are not a facility for publishing on the basis of weak data and/or weak conceptual underpinning. In the majority of cases, authors will have

submitted the paper in the Short Research Note format. In some instances, however, the Editors may feel that a full paper is best reviewed in a Short Research Note format, or the referees may only recommend publication under this format. All articles in this format will be officially designated and published with the preface 'Short Research Note:' These are placed towards the back of the journal. Acceptance for publication on this basis will be indicated in writing to the authors by the Editor or Associate Editor if the original submission was in full paper format.

3. Submission and reviewing

All manuscripts must be submitted via Editorial Manager. The Journal operates a policy of anonymous (double blind) peer review. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the terms and conditions of submission and the declaration of competing interests. You may also like to use the Submission Checklist to help you prepare your paper.

4. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. You may like to use this template. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the Project CRediT website for a list of roles.

• All articles should be preceded by an Abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article. The abstract should not include any sub-headings.

• All articles must include Practitioner Points – these are 2-4 bullet points, following the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professional practice. (Please include the 'Practitioner Points' in your main document but do not submit them to Editorial Manager with your abstract.)

• The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and always refer to any previous work in the third person.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled with symbols in a form consistent with text use. Unnecessary background patterns,

lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.

• All articles should contain a clear statement of where and when any data were collected.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide doi numbers where possible for journal articles. For example:

Author, A., Author, B., & Author, C. (1995). *Title of book*. City, Country: Publisher.
Author, A. (2013). Title of journal article. *Name of journal, 1,* 1-16. doi: 10.1111/bjep.12031

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

If you need more information about submitting your manuscript for publication, please email Hannah Wakley, Managing Editor (joop@wiley.com) or phone +44 (0) 116 252 9504.

5. Cross-sectional self-report data

Studies conducted using only cross-sectional self-report data will be considered only in exceptional circumstances. For example; if the sample is exceptionally large, representative or multiple. In all other cases, cross-sectional self-report data should form part of a wider selection of data, including other measures such as longitudinal or experimental elements, corroborating or comparison data, third party records or psycho-physiological data.

For more details on the use of cross-sectional self-report data please see the December 2011 Editorial.

6. Non-working Populations

Papers based entirely on non-working populations (e.g. student samples) will only be considered in rather unusual circumstances. The Editor retains discretion to publish this kind of data, for instance where it is clearly demonstrated that the data obtained can be generalised to working populations.

7. Supporting Information

Supporting Information can be a useful way for an author to include important but ancillary information with the online version of an article. Examples of Supporting Information include appendices, additional tables, data sets, figures, movie files, audio clips, and other related nonessential multimedia files. Supporting Information should be cited within the article text, and a descriptive legend should be included. Please indicate clearly on submission which material is for online only publication. It is published as supplied by the author, and a proof is not made available prior to publication; for these reasons, authors should provide any Supporting Information in the desired final format.

For further information on recommended file types and requirements for submission, please visit the <u>Supporting Information</u> page in Author Services.

Appendix E

Ethics Committee Study Approval

Ethics Feedback - EC.16.11.08.4753R - Google Chrome

Secure | https://outlook.office.com/owa/projection.aspx

Reply all | ⌄   🗑 Delete   Junk | ⌄   •••

Ethics Feedback - EC.16.11.08.4753R

P   **psychethics**
Mon 05/12/2016 11:23
To: Cathy McLellan; Elisabeth Summers; Reginald Morris ⌃

Reply all | ⌄

Inbox

You replied on 05/12/2016 20:35.

Dear Cathy & Elisabeth

The Ethics Committee has considered your revised project proposal: The development of a psychometric measure to assess the wellbeing of psychological practitioners (EC.16.11.08.4753R).

The project has now been approved.

Please note that if any changes are made to the above project then you must notify the Ethics Committee.

Best wishes,
Mark Jones

Appendix F

Division of Clinical Psychology Letter of Consent

The British
Psychological Society
Promoting excellence in psychology

Dr Esther Cohen-Tovée
BPS Division of Clinical Psychology UK Chair
Clinical Director, Psychological Services
Northumberland, Tyne and Wear NHS FT

ECT/fmc

26 October 2016

Ethics Committee
School of Psychology
Cardiff University
Tower Building
70 Park Place
Cardiff   CF10 3AT

To whom it may concern:

Project Title: The Development of a Psychometric Measure to Assess the Wellbeing of Psychological Practitioners

On behalf of the British Psychological Society's Division of Clinical Psychology (DCP), I am happy to support this project by providing access to participants and requesting their contribution to focus groups/interviews as well as responses to questionnaires.   The request can go out via direct email to all DCP members. Members would opt-in according to their own preferences.

The DCP promotes the interests of Clinical Psychology and Clinical Psychologists in the UK. It has approximately 12,000 members including qualified clinical psychologists, trainee clinical psychologists and affiliate members.

Please contact me if you require further information. For further information about the BPS and the DCP, see our website www.bps.org.uk

Yours faithfully

Dr Esther Cohen-Tovée
BPS Division of Clinical Psychology UK Chair
Clinical Director, Psychological Services
Northumberland, Tyne and Wear NHS Foundation Trust

Address for Correspondence
Dr Esther Cohen-Tovée
Clinical Director Psychological Services
St Nicholas House
St Nicholas Hospital
Jubilee Road
Newcastle upon Tyne   NE3 3XT

Tel: 0191 2456618
Mobile: 07795 476 494
Email: DCPUKChairDrEstherCohen-Tovee@ntw.nhs.uk

Appendix G

Psychological Professions Network North West Letter of Consent

PPN
NORTH WEST
Psychological
Professions Network
PROMOTING EXCELLENCE IN PSYCHOLOGICAL HEALTH & WELL-BEING

Centre for Professional Workforce Development
Health Education England working across the North West
St James's House 5th Floor
Emerson Business Centre Suite 21
Pendleton Way
Salford
M6 5FW

Ethics Committee
School of Psychology
Cardiff University
Tower Building
70 Park Place
Cardiff
CF10 3AT

To whom it may concern

Project Title : The Development of a Psychometric Measure to Assess the Wellbeing of Psychological Practitioners

On behalf of the Psychological Professions Network North West, I am happy to support this project by providing access to participants and requesting their contribution to focus groups/interviews as well as responses to questionnaires. . The request can go out via direct email to all the members and/or via our weekly news bulletin. Members would opt-in according to their own preferences.

The Psychological Professions Network North West is a workforce network open to all psychological professionals and those with an interest in this area. It is supported by Health Education England in the North West and current membership is around 1700 members. Most are psychological professionals working in the North West but there are also members from other parts of the UK (predominantly England).

Please contact me if you require further information. For further information about the Psychological Professions Network North West, please visit www.nwppn.nhs.uk .

Yours faithfully

Dr Gita Bhutani
Chair of the Psychological Professions Network North West

Continued.../

Address for Correspondence (my substantive role):
Dr Gita Bhutani
Associate Director for Psychological Professions
Lancashire Care NHS Foundation Trust
Trust HQ
Sceptre Point
Sceptre Way
Walton Summit
Bamber Bridge
Preston
PR5 6AW

Tel: 01772 676058
Mobile: 07507 847603
Email: gita.bhutani@lancashirecare.nhs.uk

Appendix H

Stage 2: Items Retained Following Item Review

Construct: Friends and family - Support

- The personal support I receive from family and/or friends meets my needs
- I feel there are people who care about me in my personal life
- I do not have anyone in my life with whom I can discuss personal matters
- I do not feel there is always someone there for me when I need personal support

Construct: Colleagues - Support

- I feel I can seek support from my colleagues
- I work in an environment where my colleagues are caring and supportive towards each other
- I have experienced or witnessed bullying or harassment from colleagues
- I work in an environment where there is a culture of colleagues not supporting one another

Construct: Clinical supervision - Support

- I do not feel supported by my clinical supervisor
- I do not feel I have enough clinical supervision
- The clinical supervision I receive is containing and safe
- Clinical supervision meets my support needs

Construct: Line-management - Support

- I am not supported by my line-manager
- My line-manager is approachable and responsive
- I do not feel my line-manager understands my support needs
- I feel supported by my line-manager to take positive risks without fear of reproach

Construct: Organisational targets

- I feel organisational/service targets are meaningful
- I feel organisational/service targets are attainable
- I feel pressured to reach unrealistic or unattainable targets
- Having to achieve targets distracts me from the real point of my work

Construct: Organisational hopefulness/ hopelessness

- I feel confident the organisation/service in which I work can adapt to meet future service demands
- I feel confident the organisation/service in which I work will thrive
- I cannot see how the organisation/service in which I work can ever be delivered effectively
- I cannot see a positive future for the organisation/service in which I work

Construct: Organisational engagement

- I do not feel included in service/organisational decisions that affect me
- I do not agree with the values and objectives of the service/organisation in which I work
- I feel a sense of belonging to this service/organisation in which I work
- I am proud to be a part of the service/organisation in which I work

Construct: Pressure

- I have enough time to do my job effectively
- I do not feel external pressure to work additional, unpaid hours above those that for which I am contracted
- I am often expected to do things which I do not feel capable of
- I am unable to do my job to the level I would like due to service/organisational pressures

Construct: Control and autonomy over work

- I am enabled to manage and organise my workload and diary
- I feel I can balance less fulfilling aspects of my job with more enjoyable aspects
- I do not have freedom to manage my own workload and diary
- I am not able to organise my work at a pace that suits me

Construct: Feeling valued

- My specific professional skills are not valued by my colleagues
- My colleagues value my professional contribution
- My specific skills as a psychological practitioner add value to the organisation/service/team
- I do not feel I am a valued member of my organisation/service/team

Construct: Opportunities to learn

- I do not get the opportunity to learn new skills
- My continuing professional development needs are supported
- My opportunities for continuing professional development are restricted
- I am encouraged and supported to develop my skill-set and knowledge

Construct: Physical environment and facilities

- The physical environment and/or facilities in my workplace have a negative impact on my work
- The physical environment and facilities in my workplace enable me to work efficiently and effectively
- The physical environment and/ or facilities in my workplace adversely affect my workplace wellbeing
- The physical environment and facilities in my workplace promote workplace wellbeing

Construct: Work/ life balance

- I have a good work/life balance
- My work duties encroach on my personal time
- Flexible working arrangements are supported in my organisation/ service
- My organisation/ service acknowledges that sometimes I need to put myself first

Construct: Professional line management

- My line manager understands my profession/professional duties
- My line manager supports my professional development and pathway
- My line manager does not consider my individual needs within the service/team in which I work
- My line manager shows no interest in what I do

Construct: Role Clarity

- I am clear of my role in relation to other professionals with whom I work
- There is no clear role differentiation within the organisation/service in which I work
- My colleagues have realistic expectations of my professional role
- I am often asked do things that are not in my professional remit

Appendix I

Stage 3: Construct Review Results

Intended Construct: Support - Friends and Family

Item: The personal support I receive from family and/or friends meets my needs

Selected Construct	%	Frequency (n=26)
Support - Friends and family	**88.46**	**23**
Pressure	3.85	1
Feeling valued	7.69	2

Intended Construct: Support - Friends and Family

Item: I do not have anyone in my life with whom I can discuss personal matters

Selected Construct	%	Frequency (n=26)
Support - Friends and family	**88.46**	**23**
Support - Clinical supervisor	3.85	1
Work/ life balance	7.69	2

Intended Construct: Support - Friends and Family

Item: I feel there are people who care about me in my personal life

Selected Construct	%	Frequency (n=26)
Support - Friends and family	**88.46**	**23**
Feeling valued	7.69	2
Work/ life balance	3.85	1

Intended Construct: Support - Friends and Family

Item: I do not feel there is always someone there for me when I need personal support

Selected Construct	%	Frequency (n=26)
Support - Friends and family	**73.08**	**19**
Support - Colleagues	11.54	3
Support - Clinical supervisor	11.54	3
Support - Line-manager	3.85	1

Intended Construct: Support - Colleagues

Item: I have experienced or witnessed bullying or harassment from colleagues

Selected Construct	%	Frequency (n=26)
Support - Colleagues	**73.08**	**19**
Support - Line-manager	11.54	3
Pressure	7.69	2
Feeling valued	7.69	2

Intended Construct: Support - Colleagues

Item: I work in an environment where there is a culture of colleagues not supporting one another

Selected Construct	%	Frequency (n=26)
Support - Colleagues	**76.92**	**20**
Support - Line-manager	11.54	3
Organisational engagement	7.69	2
Feeling valued	3.85	1

Intended Construct: Support - Colleagues

Item: I feel I can seek support from my colleagues

Selected Construct	%	Frequency (n=26)
Support - Colleagues	**96.15**	**25**
Feeling valued	3.85	1

Intended Construct: Support - Colleagues

Item: I work in an environment where my colleagues are caring and supportive towards each other

Selected Construct	%	Frequency (n=26)
Support - Colleagues	**88.46**	**23**
Organisational hopefulness/ hopelessness	3.85	1
Feeling valued	7.69	2

Intended Construct: Support - Clinical Supervisor

Item: Clinical supervision meets my support needs

Selected Construct	%	Frequency (n=26)
Support - Clinical supervisor	**88.46**	**23**
Support - Line-manager	3.85	1
Feeling valued	3.85	1
Professional line-management	3.85	1

Intended Construct: Support - Clinical Supervisor

Item: I do not feel supported by my clinical supervisor

Selected Construct	%	Frequency (n=26)
Support - Clinical supervisor	**92.31**	**24**
Support - Line-manager	3.85	1
Organisational engagement	3.85	1

Intended Construct: Support - Clinical Supervisor

Item: The clinical supervision I receive is containing and safe

Selected Construct	%	Frequency (n=26)
Support - Clinical supervisor	**96.15**	**25**
Feeling valued	3.85	1

Intended Construct: Support - Clinical Supervisor

Item: I do not feel I have enough clinical supervision

Selected Construct	%	Frequency (n=26)
Support - Clinical supervisor	**92.31**	**24**
Support - Line-manager	3.85	1
Feeling valued	3.85	1

Intended Construct: Support - Line Manager

Item: I do not feel my line-manager understands my support needs

Selected Construct	%	Frequency (n=26)
Support - Line-manager	**69.23**	**18**
Pressure	7.69	2
Professional line-management	23.08	6

Intended Construct: Support - Line Manager

Item: I am not supported by my line-manager

Selected Construct	%	Frequency (n=26)
Support - Line-manager	**88.46**	**23**
Feeling valued	3.85	1
Professional line-management	7.69	2

Intended Construct: Support - Line Manager

Item: My line-manager is approachable and responsive

Selected Construct	%	Frequency (n=26)
Support - Line-manager	**84.62**	**22**
Professional line-management	15.38	4

Intended Construct: Support - Line Manager

Item: I feel supported by my line-manager to take positive risks without fear of reproach

Selected Construct	%	Frequency (n=26)
Support - Line-manager	**92.31**	**24**
Work control and autonomy	7.69	2

Intended Construct: Professional Line- Management

Item: My line manager understands my profession/professional duties

Selected Construct	%	Frequency (n=26)
Support - Line-manager	**46.15**	**12**
Feeling valued	3.85	1
Professional line-management	34.62	9
Role clarity	15.38	4

Intended Construct: Professional Line- Management

Item: My line manager shows no interest in what I do

Selected Construct	%	Frequency (n=26)
Support - Line-manager	**50.00**	**13**
Feeling valued	26.92	7
Professional line-management	23.08	6

Intended Construct: Professional Line- Management

Item: My line manager supports my professional development and pathway

Selected Construct	%	Frequency (n=26)
Support - Line-manager	**50.00**	**13**
Opportunities to learn	26.92	7
Professional line-management	23.08	6

Intended Construct: Professional Line- Management

Item: My line manager does not consider my individual needs within the service in which I work

Selected Construct	%	Frequency (n=26)
Support - Line-manager	**73.08**	**19**
Feeling valued	3.85	1
Professional line-management	23.08	6

Intended Construct: Organisational Targets

Item: Having to achieve targets distracts me from the real point of my work

Selected Construct	%	Frequency (n=26)
Organisational targets	**69.23**	**18**
Pressure	15.38	4
Work control and autonomy	15.38	4

Intended Construct: Organisational Targets

Item: I feel pressured to reach unrealistic or unattainable targets

Selected Construct	%	Frequency (n=26)
Organisational targets	**69.23**	**18**
Pressure	26.92	7
Professional line-management	3.85	1

Intended Construct: Organisational Targets

Item: I feel organisational/service targets are meaningful

Selected Construct	%	Frequency (n=26)
Organisational targets	**80.77**	**21**
Organisational hopefulness/ hopelessness	3.85	1
Organisational engagement	15.38	4

Intended Construct: Organisational Targets

Item: I feel organisational/service targets are attainable

Selected Construct	%	Frequency (n=26)
Organisational targets	**84.62**	**22**
Organisational hopefulness/ hopelessness	7.69	2
Organisational engagement	3.85	1
Pressure	3.85	1

Intended Construct: Organisational hopefulness/hopelessness

Item: I cannot see a positive future for the organisation/service in which I work

Selected Construct	%	Frequency (n=26)
Organisational hopefulness/ hopelessness	**96.15**	**25**
Pressure	3.85	1

Intended Construct: Organisational hopefulness/hopelessness

Item: I cannot see how the organisation/service in which I work can ever be delivered effectively

Selected Construct	%	Frequency (n=26)
Organisational targets	15.38	4
Organisational hopefulness/ hopelessness	**69.23**	**18**
Organisational engagement	3.85	1
Pressure	11.54	3

Intended Construct: Organisational hopefulness/hopelessness

Item: I feel confident the organisation/service in which I work can adapt to meet future service demands

Selected Construct	%	Frequency (n=26)
Organisational targets	15.38	4
Organisational hopefulness/ hopelessness	**73.08**	**19**
Organisational engagement	11.54	3

Intended Construct: Organisational hopefulness/hopelessness

Item: I feel confident the organisation/service in which I work will thrive

Selected Construct	%	Frequency (n=26)
Organisational hopefulness/ hopelessness	**88.46**	**23**
Organisational engagement	7.69	2
Feeling valued	3.85	1

Intended Construct: Organisational Engagement

Item: I am proud to be a part of the organisation/service in which I work

Selected Construct	%	Frequency (n=26)
Organisational targets	3.85	1
Organisational hopefulness/ hopelessness	23.08	6
Organisational engagement	**61.54**	**16**
Feeling valued	11.54	3

Intended Construct: Organisational Engagement

Item: I do not feel included in organisation/service decisions that affect me

Selected Construct	%	Frequency (n=26)
Organisational targets	7.69	2
Organisational hopefulness/ hopelessness	3.85	1
Organisational engagement	**76.92**	**20**
Work control and autonomy	11.54	3

Intended Construct: Organisational Engagement

Item: I do not agree with the values and objectives of the organisation/service in which I work

Selected Construct	%	Frequency (n=26)
Support - Colleagues	3.85	1
Organisational targets	23.08	6
Organisational hopefulness/ hopelessness	11.54	3
Organisational engagement	**61.54**	**16**

Intended Construct: Organisational Engagement

Item: I feel a sense of belonging to the organisation/ service in which I work

Selected Construct	%	Frequency (n=26)
Support - Colleagues	3.85	1
Organisational hopefulness/ hopelessness	3.85	1
Organisational engagement	**73.08**	**19**
Feeling valued	19.23	5

Intended Construct: Pressure

Item: I have enough time to do my job effectively

Selected Construct	%	Frequency (n=26)
Support - Line-manager	3.85	1
Pressure	**46.15**	**12**
Work control and autonomy	38.46	10
Work/ life balance	11.54	3

Intended Construct: Pressure

Item: I do not feel external pressure to work additional, unpaid hours above those that for which I am contracted

Selected Construct	%	Frequency (n=26)
Support - Clinical supervisor	7.69	2
Support - Line-manager	7.69	2
Organisational targets	3.85	1
Pressure	**30.77**	**8**
Work control and autonomy	19.23	5
Work/ life balance	**30.77**	**8**

Intended Construct: Pressure

Item: I am often expected to do things which I do not feel capable of

Selected Construct	%	Frequency (n=26)
Support - Clinical supervisor	7.69	2
Pressure	**46.15**	**12**
Work control and autonomy	11.54	3
Professional line-management	11.54	3
Role clarity	23.08	6

Intended Construct: Pressure

Item: I am unable to do my job to the level I would like due to organisational/service pressures

Selected Construct	%	Frequency (n=26)
Organisational targets	30.77	8
Organisational hopefulness/ hopelessness	11.54	3
Organisational engagement	3.85	1
Pressure	**50.00**	**13**
Work control and autonomy	3.85	1

Intended Construct: Work Control and Autonomy

Item: I feel I can balance less fulfilling aspects of my job with more enjoyable aspects

Selected Construct	%	Frequency (n=26)
Support - Clinical supervisor	3.85	1
Support - Line-manager	3.85	1
Work control and autonomy	**84.62**	**22**
Work/ life balance	3.85	1
Professional line-management	3.85	1

Intended Construct: Work Control and Autonomy

Item: I am not able to organise my work at a pace that suits me

Selected Construct	%	Frequency (n=26)
Support - Clinical supervisor	3.85	1
Organisational targets	7.69	2
Pressure	15.38	4
Work control and autonomy	**73.08**	**19**

Intended Construct: Work Control and Autonomy

Item: I do not have freedom to manage my own workload and diary

Selected Construct	%	Frequency (n=26)
Support - Line-manager	3.85	1
Work control and autonomy	**92.31**	**24**
Professional line-management	3.85	1

Intended Construct: Work Control and Autonomy

Item: I am enabled to manage and organise my workload and diary

Selected Construct	%	Frequency (n=26)
Work control and autonomy	**96.15**	**25**
Work/ life balance	3.85	1

Intended Construct: Feeling Valued

Item: My specific skills as a psychological practitioner add value to the organisation/service

Selected Construct	%	Frequency (n=26)
Organisational hopefulness/ hopelessness	3.85	1
Organisational engagement	3.85	1
Feeling valued	**92.31**	**24**

Intended Construct: Feeling Valued

Item: My colleagues value my professional contribution

Selected Construct	%	Frequency (n=26)
Support - Friends and family	3.85	1
Support - Colleagues	38.46	10
Feeling valued	**57.69**	**15**

Intended Construct: Feeling Valued

Item: My specific professional skills are not valued by my colleagues

Selected Construct	%	Frequency (n=26)
Support - Colleagues	26.92	7
Organisational hopefulness/ hopelessness	3.85	1
Feeling valued	**65.38**	**17**
Role clarity	3.85	1

Intended Construct: Feeling Valued

Item: I do not feel I am a valued member of my organisation/service

Selected Construct	%	Frequency (n=26)
Organisational hopefulness/ hopelessness	7.69	2
Organisational engagement	7.69	2
Feeling valued	**84.62**	**22**

Intended Construct: Opportunities to Learn

Item: I do not get the opportunity to learn new skills

Selected Construct	%	Frequency (n=26)
Organisational engagement	3.85	1
Feeling valued	3.85	1
Opportunities to learn	**88.46**	**23**
Professional line-management	3.85	1

Intended Construct: Opportunities to Learn

Item: I am encouraged and supported to develop my skill-set and knowledge

Selected Construct	%	Frequency (n=26)
Support - Line-manager	7.69	2
Feeling valued	7.69	2
Opportunities to learn	**84.62**	**22**

Intended Construct: Opportunities to Learn

Item: My continuing professional development needs are supported

Selected Construct	%	Frequency (n=26)
Support - Line-manager	15.38	4
Organisational engagement	3.85	1
Opportunities to learn	**69.23**	**18**
Professional line-management	11.54	3

Intended Construct: Opportunities to Learn

Item: My opportunities for continuing professional development are restricted

Selected Construct	%	Frequency (n=26)
Support - Line-manager	3.85	1
Pressure	3.85	1
Feeling valued	3.85	1
Opportunities to learn	**84.62**	**22**
Professional line-management	3.85	1

Intended Construct: Physical Environment

Item: The physical environment and facilities in my workplace enable me to work efficiently and effectively

Selected Construct	%	Frequency (n=26)
Support - Colleagues	3.85	1
Work control and autonomy	7.69	2
Physical environment and facilities	**88.46**	**23**

Intended Construct: Physical Environment

Item: The physical environment and/or facilities in my workplace adversely affect my workplace wellbeing

Selected Construct	%	Frequency (n=26)
Support - Line-manager	3.85	1
Organisational engagement	3.85	1
Physical environment and facilities	**92.31**	**24**

Intended Construct: Physical Environment

Item: The physical environment and/or facilities in my workplace have a negative impact on my work

Selected Construct	%	Frequency (n=26)
Organisational engagement	3.85	1
Physical environment and facilities	**92.31**	**24**
Professional line-management	3.85	1

Intended Construct: Physical Environment

Item: The physical environment and facilities in my workplace promote workplace wellbeing

Selected Construct	%	Frequency (n=26)
Work control and autonomy	3.85	1
Physical environment and facilities	**96.15**	**25**

Intended Construct: Work/life balance

Item: I have a good work/life balance

Selected Construct	%	Frequency (n=26)
Pressure	3.85	1
Work control and autonomy	3.85	1
Work/ life balance	**92.31**	**24**

Intended Construct: Work/life balance

Item: My work duties encroach on my personal time

Selected Construct	%	Frequency (n=26)
Organisational targets	7.69	2
Work control and autonomy	3.85	1
Work/ life balance	**88.46**	**23**

Intended Construct: Work/life balance

Item: Flexible working arrangements are supported in my organisation/ service

Selected Construct	%	Frequency (n=26)
Support - Line-manager	15.38	4
Work control and autonomy	15.38	4
Work/ life balance	**65.38**	**17**
Professional line-management	3.85	1

Intended Construct: Work/life balance

Item: My organisation/ service acknowledges that sometimes I need to put myself first

Selected Construct	%	Frequency (n=26)
Pressure	7.69	2
Work control and autonomy	7.69	2
Feeling valued	15.38	4
Work/ life balance	**69.23**	**18**

Intended Construct: Role Clarity

Item: I am clear about my role in relation to other professionals with whom I work

Selected Construct	%	Frequency (n=26)
Support - Colleagues	3.85	1
Organisational targets	7.69	2
Professional line-management	3.85	1
Role clarity	**84.62**	**22**

Intended Construct: Role Clarity

Item: My colleagues have realistic expectations of my professional role

Selected Construct	%	Frequency (n=26)
Support - Colleagues	30.77	8
Feeling valued	3.85	1
Role clarity	**65.38**	**17**

Intended Construct: Role Clarity

Item: There is no clear role differentiation within the organisation/service in which I work

Selected Construct	%	Frequency (n=26)
Organisational hopefulness/ hopelessness	3.85	1
Professional line-management	3.85	1
Role clarity	**92.31**	**24**

Intended Construct: Role Clarity

Item: I am often asked do things that are not in my professional remit

Selected Construct	%	Frequency (n=26)
Organisational targets	3.85	1
Pressure	3.85	1
Work control and autonomy	11.54	3
Role clarity	**80.77**	**21**

Appendix J

Stage 3: Retained Items

Construct: Friends and family support

- The personal support I receive from family and/or friends meets my needs
- I feel there are people who care about me in my personal life
- I do not have anyone in my life with whom I can discuss personal matters
- I do not feel there is always someone there for me when I need personal support

Construct: Colleague support

- I feel I can seek support from my colleagues
- I work in an environment where my colleagues are caring and supportive towards each other
- I have experienced or witnessed bullying or harassment from colleagues
- I work in an environment where there is a culture of colleagues not supporting one another

Construct: Clinical supervision support

- I do not feel supported by my clinical supervisor
- I do not feel I have enough clinical supervision
- The clinical supervision I receive is containing and safe
- Clinical supervision meets my support needs

Construct: Support - Line-management support

- I am not supported by my line-manager
- My line-manager is approachable and responsive
- I feel supported by my line-manager to take positive risks without fear of reproach
- My line manager does not consider my individual needs within the service/team in which I work

Construct: Organisational targets

- I feel organisational/service targets are meaningful
- I feel organisational/service targets are attainable
- I am expected to reach unrealistic or unattainable targets
- Having to achieve targets distracts me from the real point of my work

Construct: Organisational hopefulness/ hopelessness

- I feel confident the organisation/service in which I work can adapt to meet future service demands
- I feel confident the organisation/service in which I work will thrive
- I cannot see how the organisation/service in which I work can ever be delivered effectively
- I cannot see a positive future for the organisation/service in which I work

Construct: Organisational engagement

- I do not feel included in service/organisational decisions that affect me
- I do not agree with the values and objectives of the service/organisation in which I work
- I feel a sense of belonging to this service/organisation in which I work
- I am proud to be a part of the service/organisation in which I work

Construct: Work control and autonomy

- I am enabled to manage and organise my workload and diary
- I feel I can balance less fulfilling aspects of my job with more enjoyable aspects
- I do not have freedom to manage my own workload and diary
- I am not able to organise my work at a pace that suits me

Construct: Feeling valued

- My specific professional skills are not valued by my colleagues
- My colleagues value my professional contribution
- My specific skills as a psychological practitioner add value to the organisation/service/team
- I do not feel I am a valued member of my organisation/service/team

Construct: Opportunities to learn

- I do not get the opportunity to learn new skills
- My continuing professional development needs are supported
- My opportunities for continuing professional development are restricted
- I am encouraged and supported to develop my skill-set and knowledge

Construct: Physical environment and facilities

- The physical environment and/or facilities in my workplace have a negative impact on my work
- The physical environment and facilities in my workplace enable me to work efficiently and effectively
- The physical environment and/ or facilities in my workplace adversely affect my workplace wellbeing
- The physical environment and facilities in my workplace promote workplace wellbeing

Construct: Work/ life balance

- I have a good work/life balance
- My work duties encroach on my personal time
- Flexible working arrangements are supported in my organisation/ service
- My organisation/ service acknowledges that sometimes I need to put myself first

Construct: Role Clarity

- I am clear about my role in relation to other professionals with whom I work
- There is no clear role differentiation within the organisation/service in which I work
- My colleagues have realistic expectations of my professional role
- I am often asked do things that are not in my professional remit

Appendix K

Stage 4: Item Ranking Results

Friends and family support (n= 39)

	The personal support I receive from family and/or friends meets my needs	I feel there are people who care about me in my personal life	I do not have anyone in my life with whom I can discuss personal matters	I do not feel there is always someone there for me when I need personal support
Mean	2.00	2.74	2.97	2.28
Median	2.00	3.00	3.00	2.00
Mode	1	3	4	1
Std. Deviation	1.076	1.117	.932	1.123
Variance	1.158	1.248	.868	1.260
Sum	78	107	116	89

Support – Colleagues (n= 39)

	I feel I can seek support from my colleagues	I work in an environment where my colleagues are caring and supportive towards each other	I have experienced or witnessed bullying or harassment from colleagues	I work in an environment where there is a culture of colleagues not supporting one another
Mean	1.85	2.13	3.00	3.03
Median	2.00	2.00	3.00	3.00
Mode	2	1	4	4
Std. Deviation	.875	1.128	1.026	.959
Variance	.765	1.273	1.053	.920
Sum	72	83	117	118

Support - Clinical supervisor (n= 39)

	I do not feel supported by my clinical supervisor	I do not feel I have enough clinical supervision	The clinical supervision I receive is containing and safe	Clinical supervision meets my support needs
Mean	2.95	2.87	1.97	2.21
Median	3.00	3.00	1.00	2.00
Mode	4	3	1	2
Std. Deviation	.999	.923	1.246	1.005
Variance	.997	.852	1.552	1.009
Sum	115	112	77	86

Support - Line-manager (n= 39)

	I am not supported by my line-manager	My line-manager is approachable and responsive	I feel supported by my line-manager to take positive risks without fear of reproach	My line manager does not consider my individual needs within the service/team in which I work
Mean	2.56	2.28	2.41	2.74
Median	3.00	2.00	2.00	3.00
Mode	2	1	2	4
Std. Deviation	1.095	1.146	1.044	1.186
Variance	1.200	1.313	1.090	1.406
Sum	100	89	94	107

Organisational targets (n= 39)

	I feel organisational/ service targets are meaningful	I feel organisational/ service targets are attainable	I am expected to reach unrealistic or unattainable targets	Having to achieve targets distracts me from the real point of my work
Mean	2.31	2.67	2.26	2.77
Median	2.00	3.00	2.00	3.00
Mode	1	2	1	4
Std. Deviation	1.151	1.009	1.186	1.087
Variance	1.324	1.018	1.406	1.182
Sum	90	104	88	108

Organisational hopefulness/ hopelessness (n= 39)

	I feel confident the organisation/ service in which I work can adapt to meet future service demands	I feel confident the organisation/ service in which I work will thrive	I cannot see how the organisation/ service in which I work can ever be delivered effectively	I cannot see a positive future for the organisation/ service in which I work
Mean	1.85	2.87	2.54	2.74
Median	1.00	3.00	3.00	3.00
Mode	1	4	3	3[a]
Std. Deviation	1.089	1.056	.996	1.093
Variance	1.186	1.115	.992	1.196
Sum	72	112	99	107

Organisational engagement (n= 39)

	I do not feel included in service/ organisational decisions that affect me	I do not agree with the values and objectives of the service/ organisation in which I work	I feel a sense of belonging to this service/ organisation in which I work	I am proud to be a part of the service/ organisation in which I work
Mean	2.23	3.03	2.00	2.74
Median	2.00	3.00	2.00	3.00
Mode	3	4	1[a]	2[a]
Std. Deviation	1.063	1.135	.946	1.069
Variance	1.130	1.289	.895	1.143
Sum	87	118	78	107

Work control and autonomy (n= 39)

	I am enabled to manage and organise my workload and diary	I feel I can balance less fulfilling aspects of my job with more enjoyable aspects	I do not have freedom to manage my own workload and diary	I am not able to organise my work at a pace that suits me
Mean	1.67	2.69	2.77	2.87
Median	1.00	3.00	3.00	3.00
Mode	1	2	3	3
Std. Deviation	1.009	1.004	1.012	1.056
Variance	1.018	1.008	1.024	1.115
Sum	65	105	108	112

Feeling valued (n= 39)

	My specific professional skills are not valued by my colleagues	My colleagues value my professional contribution	My specific skills as a psychological practitioner add value to the organisation/ service/team	I do not feel I am a valued member of my organisation/ service/team
Mean	3.08	1.82	2.51	2.59
Median	3.00	2.00	3.00	3.00
Mode	4	1	3	3
Std. Deviation	.984	.997	1.048	1.117
Variance	.968	.993	1.099	1.248
Sum	120	71	98	101

Opportunities to learn (n= 39)

	I do not get the opportunity to learn new skills	My continuing professional development needs are supported	My opportunities for continuing professional development are restricted	I am encouraged and supported to develop my skill-set and knowledge
Mean	3.23	1.95	2.64	2.18
Median	4.00	2.00	3.00	2.00
Mode	4	1	3	1
Std. Deviation	1.038	.916	.959	1.144
Variance	1.077	.839	.920	1.309
Sum	126	76	103	85

Physical environment and facilities (n= 39)

	The physical environment and/or facilities in my workplace have a negative impact on my work	The physical environment and facilities in my workplace enable me to work efficiently and effectively	The physical environment and/ or facilities in my workplace adversely affect my workplace wellbeing	The physical environment and facilities in my workplace promote workplace wellbeing
Mean	2.77	2.51	1.87	2.85
Median	3.00	3.00	2.00	3.00
Mode	4	3	1	4
Std. Deviation	1.202	.997	.894	1.136
Variance	1.445	.993	.799	1.291
Sum	108	98	73	111

Work/ life balance (n= 39)

	I have a good work/life balance	My work duties encroach on my personal time	Flexible working arrangements are supported in my organisation/ service	My organisation/ service acknowledges that sometimes I need to put myself first
Mean	2.05	2.69	2.26	3.00
Median	2.00	3.00	2.00	3.00
Mode	1	4	2	4
Std. Deviation	1.169	1.104	.910	1.076
Variance	1.366	1.219	.827	1.158
Sum	80	105	88	117

Role Clarity (n= 39)

	I am clear of my role in relation to other professionals with whom I work	There is no clear role differentiation within the organisation/ service in which I work	My colleagues have realistic expectations of my professional role	I am often asked do things that are not in my professional remit
Mean	1.95	2.90	2.28	2.87
Median	1.00	3.00	2.00	3.00
Mode	1	4	2	3
Std. Deviation	1.191	1.095	.916	1.005
Variance	1.418	1.200	.839	1.009
Sum	76	113	89	112

Appendix L

Stage 4: Items for Inclusion in Final Measure

Friends and family - Support

- The personal support I receive from family and/or friends meets my needs
- I do not feel there is always someone there for me when I need personal support

Colleagues - Support

- I feel I can seek support from my colleagues
- I work in an environment where my colleagues are caring and supportive towards each other

Clinical supervision - Support

- The clinical supervision I receive is containing and safe
- Clinical supervision meets my support needs

Support - Line-management

- My line-manager is approachable and responsive
- I feel supported by my line-manager to take positive risks without fear of reproach

Organisational targets

- I feel organisational/service targets are meaningful
- I am expected to reach unrealistic or unattainable targets

Organisational hopefulness/ hopelessness

- I feel confident the organisation/service in which I work can adapt to meet future service demands
- I cannot see how the organisation/service in which I work can ever be delivered effectively

Organisational engagement

- I do not feel included in service/organisational decisions that affect me
- I feel a sense of belonging to this service/organisation in which I work

Work control and autonomy

- I am enabled to manage and organise my workload and diary
- I feel I can balance less fulfilling aspects of my job with more enjoyable aspects

Feeling valued

- My colleagues value my professional contribution
- My specific skills as a psychological practitioner add value to the organisation/service/team

Opportunities to learn

- My continuing professional development needs are supported
- I am encouraged and supported to develop my skill-set and knowledge

Physical environment and facilities

- The physical environment and facilities in my workplace enable me to work efficiently and effectively
- The physical environment and/ or facilities in my workplace adversely affect my workplace wellbeing

Work/ life balance

- I have a good work/life balance
- Flexible working arrangements are supported in my organisation/ service

Role Clarity

- I am clear about my role in relation to other professionals with whom I work
- My colleagues have realistic expectations of my professional role

Appendix M

Psychological Practitioner Workplace Wellbeing Measure

Psychological Practitioner Workplace Wellbeing Measure©

This measure contains 26 statements about workplace wellbeing. Using the scale, please indicate your agreement with each item by selecting <u>one</u> box that best describes your experience.

Answer items based on your <u>current workplace wellbeing,</u> rather than any historical experiences.

STATEMENTS	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1. I do not feel there is always someone there for me when I need personal support	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
2. I feel I can seek support from my colleagues	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. I feel a sense of belonging to the service/organisation in which I work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. Flexible working arrangements are supported in my service/organisation	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. I feel supported by my line-manager to take positive risks without fear of reproach	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. I work in an environment where my colleagues are caring and supportive towards each other	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. I feel I can balance less fulfilling aspects of my job with more enjoyable aspects	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. I cannot see how the service/organisation in which I work can ever be delivered effectively	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
9. The clinical supervision I receive is containing and safe	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10. I am enabled to manage and organise my workload and diary	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
11. I am clear about my role in relation to other professionals with whom I work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
12. I feel confident the service/organisation in which I work can adapt to meet future service demands	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
13. Clinical supervision meets my support needs	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

STATEMENTS	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
14. My colleagues have realistic expectations of my professional role	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
15. The physical environment and facilities in my workplace enable me to work efficiently and effectively	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
16. My colleagues value my professional contribution	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
17. I have a good work/life balance	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
18. I do not feel included in service/organisational decisions that affect me	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
19. The personal support I receive from family and/or friends meets my needs	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
20. My line-manager is approachable and responsive	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
21. My continuing professional development needs are supported	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
22. I am encouraged and supported to develop my skill-set and knowledge	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
23. I am expected to reach unrealistic or unattainable targets	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
24. The physical environment and/or facilities in my workplace adversely affect my workplace wellbeing	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
25. I feel service/organisational targets are meaningful	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
26. My specific skills as a psychological practitioner add value to the service/team/organisation	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Validation of Psychological Practitioner Workplace Wellbeing Measure Survey

The development of a psychometric measure to assess the workplace wellbeing of psychological practitioners: phase 2

Background information:

The importance of staff wellbeing is increasingly recognised in many professional circles. There is an abundance of research detailing the strong links between staff wellbeing and the delivery of dignified and safe patient care. Despite a growing evidence base, there are currently no validated tools to specifically measure subjective workplace wellbeing of psychological practitioners.

This study is being conducted by Elisabeth Summers, Trainee Clinical Psychologist, as part of the South Wales Doctorate of Clinical Psychology qualification, supervised by Professor Reg Morris (Course Director and Clinical Psychologist, South Wales Programme in Clinical Psychology) and Dr. Gita Bhutani (Associate Director for Psychological Professions, Lancashire Care NHS Foundation Trust; Chair of the Psychological Professions Network North West; PPN). This project is linked to work being undertaken by the Division of Clinical Psychology (DCP) and New Savoy Partnership.

This study has been reviewed and approved by the Cardiff University School of Psychology Research Ethics Committee (Reference: EC.16.11.08.4753R).

Aims:

The overall aim of this research is to validate a psychometric measure to assess the workplace wellbeing of psychological practitioners. The measure has gone through many stages of development to date. Participation in this stage involves completing the new workplace wellbeing measure (some people will be asked to repeat the completion if they opt in to this), in addition to a demographic questionnaire and some previously validated measures. This will allow assessment of convergent validity and temporal stability of the new measure.

Who can participate?

You are invited to participate in this study if you are currently employed, in the UK, within an organisation (e.g. NHS, independent sector, third sector), as a psychological practitioner, in the role of: clinical

psychologist, counselling psychologist, high intensity therapist, counsellor, cognitive behaviour therapist, psychological wellbeing practitioner, arts therapist, family therapist, psychoanalyst or psychotherapist.

Unfortunately, those working solely in private practice outside of organisations and those who work outside the UK are not eligible to participate. Participation is entirely voluntary.

The survey should take approximately 15-25 minutes to complete.
Note: Some measures are protected by copyright laws. Please do not reproduce these measures.

Risks and benefits

We hope that your participation will help improve the assessment of the workplace wellbeing of psychological practitioners, which may in turn improve research in this area. We believe there are no known risks associated with this research study. However, if you should experience any adverse consequences as a result of completing the measures, you may contact Elisabeth Summers (details below). All data collected is anonymised and stored securely under password protection. Data will be kept securely for up to 5 years.

Results from this study will be written up as part of a research thesis and therefore deposited in print and online in the university archives. Results may also be published as original research. **No personally identifiable information will be published.**

Please note, this research is delivered using English language and therefore we recommend that only those proficient in English participate.

If you have any concerns or complaints, please contact:

Email: psychethics@cardiff.ac.uk
Address: School of Psychology Research Ethics Committee, Cardiff University, Tower Building, 70 Park Place, Cardiff, CF10 3AT

If you would like any further information, please contact me or my supervisor.

Contact details:
Researcher: Elisabeth Summers
Email: summerse3@cardiff.ac.uk; Telephone number: 02920870582
Address: Doctorate of Clinical Psychology, 11th Floor, Tower Building, School of Psychology, 70 Park Place, Cardiff, CF10 3AT

Academic Supervisor Contact details:
Name: Professor Reginald Morris
Email address: reg.morris@wales.nhs.uk;
Telephone number: 02920870582
Address: Doctorate in Clinical Psychology, 11th Floor, Tower Building, School of Psychology, 70 Park Place, Cardiff, CF10 3AT

Consent

I have read the information above and consent to participating in this research.

I understand that I am able to contact the researchers if I have any questions.

I understand that participation is voluntary and responses are anonymous and will be kept securely. Note: If you wish to provide your email address for involvement in further stages, this information will be kept securely.

I agree to my anonymous data being used in this study as well as future reports or publications.

I am currently working in the UK, within an organisation (e.g. NHS, independent sector, third sector), as a psychological practitioner, in the role of: clinical psychologist, counselling psychologist, high intensity therapist, counsellor, cognitive behaviour therapist, psychological wellbeing practitioner, arts therapist, psychoanalyst or psychotherapist.

I agree that I will not reproduce the copyrighted content of this survey.

If no is selected you will be directed to the final page of the survey.

    ○ Yes (1)

    ○ No (2)

Skip To: End of Survey If I have read the information above and consent to participating in this research.   I understan... = No

Demographic Information

Please answer the following questions. Where a selection of 'other' is made, please specify your answer in the text box provided. All questions must be answered.

Answers are related to your current employment as a psychological practitioner within an organisation. If you do additional private work, please **do not** include this within your answers.

1. What is your primary profession?

- Clinical Psychologist
- Counselling Psychologist
- High Intensity Therapist
- Psychological Wellbeing Practitioner
- Counsellor
- Cognitive Behaviour Therapist
- Arts Therapist
- Psychoanalyst
- Psychotherapist
- Other (please specify) _____

2. Type of appointment/ contract?

- Permanent/ Open ended
- Non-permanent/ Fixed-term
- Other (please specify) _____

3. Number of years since professional qualification?

- Up to 5 years
- 5 - 10 years
- 11 - 15 years
- 16 - 20 years
- 21 - 25 years
- 26 - 30 years
- 31 - 35 years
- 36 years or more

4. Number of years worked since professional qualification? (To account for any breaks in service)

- Up to 5 years
- 5 - 10 years
- 11 - 15 years
- 16 - 20 years
- 21 - 25 years
- 26 - 30 years
- 31 - 35 years
- 36 years or more

---

5. Number of years worked in current post?

- Up to 5 years
- 5 - 10 years
- 11 - 15 years
- 16 - 20 years
- 21 - 25 years
- 26 - 30 years
- 31 - 35 years
- 36 years or more

---

6. Number of hours per week you are contracted to work? (**Do not** include additional private work)

- Less than 7.5 hours
- 7.5 - 15 hours
- Over 15 hours - 22.5 hours
- Over 22.5 hours - 30 hours
- Over 30 hours - 37.5 hours
- Over 37.5 hours

---

7. Type of organisation in which you work? (Primary employer for whom you work the most hours)

- NHS

- Private organisation/ Independent
- Third sector/ Charitable organisation
- Equal NHS and non-NHS
- Other (please specify) _____

---

8. If you are on the Agenda for Change pay scale, what band is your current post? (Please select not applicable where appropriate to do so)

- Band 3
- Band 4
- Band 5
- Band 6
- Band 7
- Band 8a
- Band 8b
- Band 8c
- Band 8d
- Band 9
- Do not wish to disclose
- None of these bands/ not applicable

Display This Question:

If 8. If you are on the Agenda for Change pay scale, what band is your current post? (Please select... = None of these bands/ not applicable

8b. You have indicated you are not on an Agenda for Change banding. Please select your salary range from those listed below, for a full-time equivalent post.

- < £10,000
- £10,001 - £20,000
- £20,001 - £30,000
- £30,001 - £40,000
- £40,001 - £50,000
- £50,001 - £60,000
- £60,001 - £70,000
- £70,001 - £80,000
- £80,001 - £90,000
- £90,001 - £100,000
- £100,001 - £110,000
- £110,001 - £120,000
- £120,001 +

- Do not wish to disclose

---

9. What is your gender?

- Male
- Female
- Transgender
- Other (please specify) _____
- Do not wish to disclose

---

10. Do you have any long-standing illness or disability?

- Yes
- No
- Do not wish to disclose

---

11. What is your age?

- 18 - 24
- 25 - 34
- 35 - 44
- 45 - 54
- 55 - 64
- 65 - 74
- 75 or older
- Do not wish to disclose

Psychological Practitioner Workplace Wellbeing Measure

This measure contains 26 statements. Using the scale, indicate your agreement with each item. Answer items based on your **current workplace wellbeing**, rather than any historical experiences.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
1. I do not feel there is always someone there for me when I need personal support	○	○	○	○	○
2. I feel I can seek support from my colleagues	○	○	○	○	○
3. I feel a sense of belonging to the service/organisation in which I work	○	○	○	○	○
4. Flexible working arrangements are supported in my service/organisation	○	○	○	○	○
5. I feel supported by my line-manager to take positive risks without fear of reproach	○	○	○	○	○
6. I work in an environment where my colleagues are caring and supportive towards each other	○	○	○	○	○
7. I feel I can balance less fulfilling aspects of my job with more enjoyable aspects	○	○	○	○	○

Psychological Practitioner Workplace Wellbeing Measure - Continued

Using the scale, indicate your agreement with each item. Answer items based on your **current workplace wellbeing**, rather than any historical experiences.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
8. I cannot see how the service/ organisation in which I work can ever be delivered effectively	○	○	○	○	○
9. The clinical supervision I receive is containing and safe	○	○	○	○	○
10. I am enabled to manage and organise my workload and diary	○	○	○	○	○
11. I am clear about my role in relation to other professionals with whom I work	○	○	○	○	○
12. I feel confident the service/organisation in which I work can adapt to meet future service demands	○	○	○	○	○
13. Clinical supervision meets my support needs	○	○	○	○	○
14. My colleagues have realistic expectations of my professional role	○	○	○	○	○

Psychological Practitioner Workplace Wellbeing Measure - Continued

Using the scale, indicate your agreement with each item. Answer items based on your **current workplace wellbeing**, rather than any historical experiences.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
15. The physical environment and facilities in my workplace enable me to work efficiently and effectively	○	○	○	○	○
16. My colleagues value my professional contribution	○	○	○	○	○
17. I have a good work/life balance	○	○	○	○	○
18. I do not feel included in service/organisational decisions that affect me	○	○	○	○	○
19. The personal support I receive from family and/or friends meets my needs	○	○	○	○	○
20. My line-manager is approachable and responsive	○	○	○	○	○

Psychological Practitioner Workplace Wellbeing Measure - Continued

Using the scale, indicate your agreement with each item. Answer items based on your **current workplace wellbeing**, rather than any historical experiences.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
21. My continuing professional development needs are supported	○	○	○	○	○
22. I am encouraged and supported to develop my skill-set and knowledge	○	○	○	○	○
23. I am expected to reach unrealistic or unattainable targets	○	○	○	○	○
24. The physical environment and/or facilities in my workplace adversely affect my workplace wellbeing	○	○	○	○	○
25. I feel service/organisational targets are meaningful	○	○	○	○	○
26. My specific skills as a psychological practitioner add value to the team/service/organisation	○	○	○	○	○

Health and Safety Executive Management Standards Indicator Tool

This tool contains 35 questions relating to the six primary stressors identified in the Management Standards approach to tackling Work-Related Stress.

Select the item which best applies, based on your **current** experiences at work.

	Never	Seldom	Sometimes	Often	Always
1. I am clear of what is expected of me at work	○	○	○	○	○
2. I can decide when I take a break	○	○	○	○	○
3. Different groups at work demand things from me that are hard to combine	○	○	○	○	○
4. I know how to go about getting my job done	○	○	○	○	○
5. I am subject to personal harassment in the form of unkind words or behaviour	○	○	○	○	○
6. I have unachievable deadlines	○	○	○	○	○
7. If work gets difficult, my colleagues will help me	○	○	○	○	○
8. I am given supportive feedback on the work I do	○	○	○	○	○

Select the item which best applies, based on your **current** experiences at work.

	Never	Seldom	Sometimes	Often	Always
9. I have to work very intensively	○	○	○	○	○
10. I have a say in my own work speed	○	○	○	○	○
11. I am clear what my duties and responsibilities are	○	○	○	○	○
12. I have to neglect some tasks because I have too much to do	○	○	○	○	○
13. I am clear about the goals and objectives for my department	○	○	○	○	○
14. There is friction or anger between colleagues	○	○	○	○	○
15. I have a choice in deciding how I do my work	○	○	○	○	○

Select the item which best applies, based on your **current** experiences at work.

	Never	Seldom	Sometimes	Often	Always
16. I am unable to take sufficient breaks	○	○	○	○	○
17. I understand how my work fits into the overall aim of the organisation	○	○	○	○	○
18. I am pressured to work long hours	○	○	○	○	○
19. I have a choice in deciding what I do at work	○	○	○	○	○
20. I have to work very fast	○	○	○	○	○
21. I am subject to bullying at work	○	○	○	○	○
22. I have unrealistic time pressures	○	○	○	○	○
23. I can rely on my line manager to help me out with a work problem	○	○	○	○	○

Select the item which best applies, based on your **current** experiences at work.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
24. I get help and support I need from colleagues	○	○	○	○	○
25. I have some say over the way I work	○	○	○	○	○
26. I have sufficient opportunities to question managers about change at work	○	○	○	○	○
27. I receive the respect at work I deserve from my colleagues	○	○	○	○	○
28. Staff are always consulted about change at work	○	○	○	○	○
29. I can talk to my line manager about something that has upset or annoyed me about work	○	○	○	○	○

Select the item which best applies, based on your **current** experiences at work.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
30. My working time can be flexible	◯	◯	◯	◯	◯
31. My colleagues are willing to listen to my work-related problems	◯	◯	◯	◯	◯
32. When changes are made at work, I am clear how they will work out in practice	◯	◯	◯	◯	◯
33. I am supported through emotionally demanding work	◯	◯	◯	◯	◯
34. Relationships at work are strained	◯	◯	◯	◯	◯
35. My manager encourages me at work	◯	◯	◯	◯	◯

www.hse.gov.uk/stress/standards/pdfs/indicatortool.pdf

Satisfaction with Life Scale

This scale contains 5 statements that you may agree or disagree with. Using the scale below, indicate your agreement with each item.

	Strongly disagree (1)	Disagree (2)	Slightly disagree (3)	Neither agree nor disagree (4)	Slightly agree (5)	Agree (6)	Strongly agree (7)
1. In most ways my life is close to my ideal	○	○	○	○	○	○	○
2. The conditions of my life are excellent	○	○	○	○	○	○	○
3. I am satisfied with my life	○	○	○	○	○	○	○
4. So far I have gotten the important things I want in life	○	○	○	○	○	○	○
5. If I could live my life over, I would change almost nothing	○	○	○	○	○	○	○

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction with Life Scale. *Journal of Personality Assessment, 49,* 71-75.

General Health Questionnaire - (GHQ-12)

We should like to know if you have had any medical complaints and how your health has been in general, over the last few weeks. Please answer all the questions by selecting the answer which you think most nearly applies to you. Remember that we want to know about present or recent complaints, not those that you had in the past.

Have you recently...

1. been able to concentrate on whatever you're doing?	○ Better than usual	○ Same as usual	○ Less than usual	○ Much less than usual
2. lost much sleep over worry?	○ Not at all	○ No more than usual	○ Rather more than usual	○ Much more than usual
3. felt that you are playing a useful part in things?	○ More so than usual	○ Same as usual	○ Less useful than usual	○ Much less useful
4. felt capable of making decisions about things?	○ More so than usual	○ Same as usual	○ Less so than usual	○ Much less than usual
5. felt constantly under strain?	○ Not at all	○ No more than usual	○ Rather more than usual	○ Much more than usual
6. felt you couldn't overcome your difficulties?	○ Not at all	○ No more than usual	○ Rather more than usual	○ Much more than usual
7. been able to enjoy your normal day-to-day activities?	○ More so than usual	○ Same as usual	○ Less so than usual	○ Much less than usual
8. been able to face up to your problems?	○ More so than ususal	○ Same as usual	○ Less so than usual	○ Much less able

9. been feeling unhappy and depressed?	○ Not at all	○ No more than usual	○ Rather more than usual	○ Much more than usual
10. been losing confidence in yourself?	○ Not at all	○ No more than usual	○ Rather more than usual	○ Much more than usual
11. been thinking of yourself as a worthless person?	○ Not at all	○ No more than usual	○ Rather more than usual	○ Much more than usual
12. been feeling reasonably happy, all things considered?	○ More so than usual	○ About same as usual	○ Less so than usual	○ Much less than usual

----

Thank you very much for your time taken to complete this survey.

If you are happy to be contacted by email in 1-2 weeks to re-complete **only** the Psychological Practitioner Workplace Wellbeing Measure, **please provide your email address below**. You will be sent a link to complete this single measure, which will enable assessment of temporal stability of results.
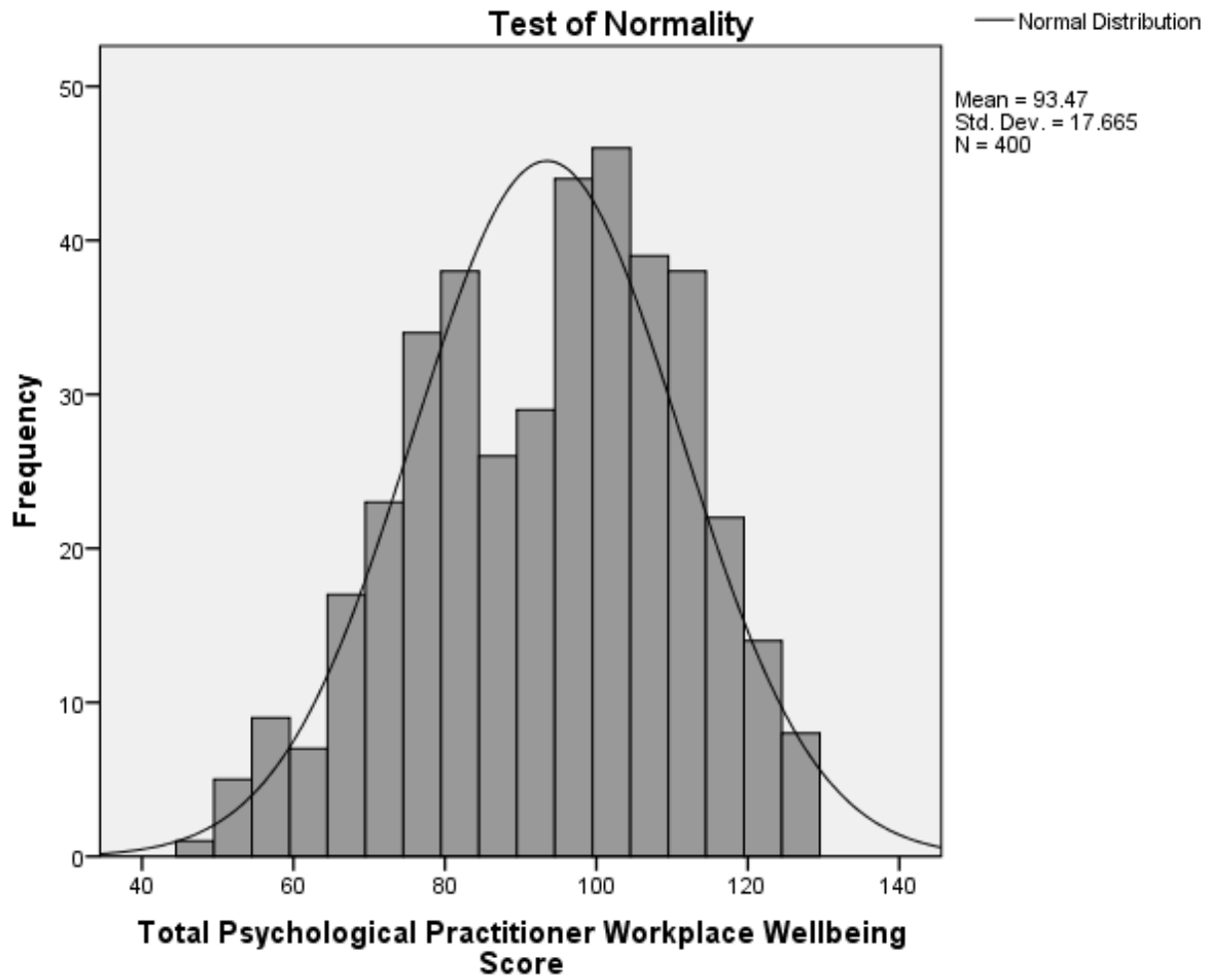
Information provided will be kept confidential and not used for any other correspondence. Your participation would be appreciated.

○ Yes (please provide email address for contact)

_____

○ No

Appendix O

Histogram: Test of Normality of PPWWM

Appendix P

Exploratory Factor Analysis Eigenvalue Scree Plot