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Abstract

The wellbeing of the psychological workforce is an area of concern. However, it has been sparsely studied in an holistic manner encompassing workplace wellbeing as well as burnout. This study reports a survey of 1,678 psychological practitioners accessed through professional networks.

The short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) and the Psychological Practitioner Workplace Wellbeing Measure (PPWWM) were administered with a demographic questionnaire. The mean for the SWEMWBS was below that of a national population survey. The inter-correlation of these tests was .61. Subgroup analyses showed significant differences: assistant psychologists, counsellors and psychological wellbeing practitioners demonstrated better than average workplace wellbeing. But for general wellbeing (SWEMWBS) trainee clinical psychologists and assistant psychologists showed lower than average wellbeing while psychological wellbeing practitioners were higher than average.

Other factors associated with wellbeing were: contract type –both measures (higher workplace wellbeing in those with temporary contracts and the self-employed); employment sector –for PPWWM only (private organisation/independent workers and third sector/charitable organisation workers scored above the PPWWM mean); ethnicity – for both measures (Asian groups except Chinese had higher wellbeing than average for the PPWWM and SWEMWBS); disability was strongly associated with lower wellbeing on both measures. Harassment, feeling depressed or a failure and wanting to leave the NHS were associated with lower wellbeing. Greater age, pay and years of service were *negatively* correlated with wellbeing.

A five-factor structure was obtained with this sample.

The results confirmed psychological practitioners as an at-risk group and identified a number of factors associated with workplace wellbeing.

Practitioner Points

- Workplace wellbeing is related to, but distinct from, general wellbeing and should be measure by a specialist instrument.
- The general wellbeing of psychological practitioners is below the national average and this requires consideration by policymakers and workforce planners.
- The association of gender and sexual orientation with wellbeing do not appear to be strong, but disability has a strong generalised association requiring further research and action.

- The associations between ethnicity and temporary contracts and wellbeing are complex and require further study.

Introduction

The mental health of psychological practitioners has become a focus of attention in recent years (Dattilio, 2015). Workplace wellbeing is a vital consideration if health services are to retain staff and deliver an effective and safe service (Health Education England, 2019; Hall et al., 2016).

Research in healthcare professional populations has focused particularly on the assessment of burnout. Burnout can be thought of as a specific form of chronic workplace psychological stress (Ruotsalainen, Verbeek, Mariné & Serra, 2015; World Health Organization, 2018). Although burnout is correlated with anxiety, depression and fatigue, burnout is thought to be distinct from mental health, from general stress and from other work phenomena such as job dissatisfaction (Maslach, Schaufeli & Leiter, 2001). In healthcare professional populations, burnout has been defined by Maslach and colleagues and is often measured by the Maslach Burnout Inventory (Maslach, Jackson, & Leiter, 1996). It 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; (3) *lack of personal accomplishment*, negative self-evaluation, particularly in relation to patient work, feelings of dissatisfaction with work accomplishments and achievements (Maslach et al., 1996; Maslach & Jackson, 1981). The Copenhagen Burnout Inventory (CBI), a further measure of burnout, has also been used in healthcare populations (Di Benedetto & Swadling, 2014; D'Souza, Egan & Rees, 2011). It was designed to have utility across different professional domains beyond healthcare (Kristensen, Borritz, Villadsen & Christensen, 2005). 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).

Table 1 shows the results of studies of burnout in psychological practitioners. The majority found evidence for higher than average burnout levels in psychological practitioners. This is concerning for the profession, but not all these studies used the established thresholds for burnout to identify ‘average’ levels (Maslach et al., 2017). Concerning results for the UK were reported by Hacker-Hughes, Rao, Dosanjh, Cohen-Tovée, Clarke & Bhutani (2016). These studies demonstrated increasingly poor wellbeing amongst psychological practitioners across successive annual surveys until 48% felt depressed, almost 50% felt like

a failure and 92% found their job stressful at least some of the time. Of additional concern is the lack of priority given to self-care in psychologists and mental health professionals. It has been proposed that despite the potential increased personal challenges associated with being a mental health professional, they are prone to avoiding treatment or support (Dattilio, 2015).

Table 1 about here

There is a little research comparing the rates of burnout across professions to allow comparison of the wellbeing of psychological practitioners with the wider mental health workforce. Most studies appear to either focus on levels of burnout in single professional groups, or levels of burnout are assessed within a single service type. However, Johnson et al. (2012) conducted a large sample of mental health professionals in England (n= 2,258) including social workers, occupational therapists, nurses, clinical psychologists, nursing assistants, psychiatrists, and service managers. They reported significant differences across the professional groups with the mean for social workers, nurses and occupational therapists reaching the threshold for high burnout while the other professions were below the threshold. In contrast, in Israel, no differences in stress or burnout were observed between 249 female psychologists, nurses and social workers, except for the depersonalization outcome of burnout, which was significantly lower among psychologists than among nurses or social workers (Ben-Zur & Michael, 2007). However, this sample size was small for detecting statistically significant subgroup differences.

Two issues with workplace wellbeing research to date are the lack of a validated measure specific to psychological practitioners and the focus on burnout and the negative facets of work experience rather than wellbeing. Maben et al., (2012) made a convincing case for considering both positive and negative aspects of workplace experience to reach an overall appraisal of employee wellbeing. This approach is echoed by models of workplace wellbeing that identify resources as positive aspects and demands or threats to resources as negative aspects (Bakker & Demerouti, 2007; Hobfoll & Shiron, 2001). Summers et al. (2020) addressed the dual problems of the lack of a validated measure of workplace wellbeing for psychological practitioners and the need to consider both the positive and negative facets of wellbeing. This research developed the Psychological Practitioner Workplace Wellbeing Measure (PPWWM), a brief 26-item measure based on items derived from a qualitative study of practitioners.

The present study used existing data collected for the annual national survey delivered by The New Savoy Partnership and Leadership and Management Faculty of the British Psychological Society, Division of Clinical Psychology. This survey was predicated by concerns for the wellbeing of the psychological workforce and was designed to inform policy and guidelines. It was sent to psychological practitioners from a range of psychological sub-professions with a focus on those delivering talking-based therapies. The

survey used the PPWWM, a generic wellbeing measure (The Short Form Warwick-Edinburgh Mental Wellbeing Scale – SWEMWBS—Stewart-Brown et al., 2009) and some specific questions from the National Health Service (UK) staff survey (NHS staff survey coordination centre, 2018).

Specific research questions included: the determination of averages for workplace wellbeing of psychological practitioner sub-groups in the UK; the exploration of subgroup differences (including profession, gender and disability); association of wellbeing with demographic variables; the correlation of the PPWWM with the SWEMWBS and its association with specific questions from the NHS staff survey relating to harassment and bullying. Since gender differences in the workforce are currently an area of interest and concern (Office for National Statistics, 2019) key results were reported separately for males and females.

Additionally, the study was designed to augment existing psychometric data for the distribution and norms of the PPWWM and its factor structure.

Method

Consent and Data Management

The study was based on a secondary analysis of an anonymised data base produced by a Division of Clinical Psychology/New Savoy Partnership survey of the UK psychology profession. In common with earlier annual surveys conducted by the Division of Clinical Psychology/New Savoy Partnership, the purpose of the original survey was to assess the state of the profession and was not construed as a research study requiring research ethical approval. The survey was conducted under the terms of the European General Data Protection Regulations (2016/679). It was anonymous from the point of data collection and no identifiable information was collected (e.g . location, IP address, etc.). Participation was voluntary and consents for use of the data were given within the survey. Participants agreed for their data to be used *“in future reports or publications.”*

Procedure

The first author was involved in the collection of data. A web-based Qualtrics® survey was created and participants were sent a web-based link for completion. The questionnaire is available as supplementary material to this paper. The survey was disseminated via psychological practitioner mailing lists, professional organisations and networks and a closed social media group for clinical psychologists. Members of the professional groups were emailed a web-based link to the survey. Individuals were encouraged to share the invitation for participation with their colleagues and professional groups (a ‘snowball’ sample). Response rate cannot be determined in such samples. The inclusion criterion was

those currently employed in a UK health/social care organisation as a psychological practitioner.

Measures

The Qualtrics® survey included a demographic survey, the PPWWM (Summers, et al., 2020), The Short Warwick-Edinburgh Mental Well-being Scale (Stewart-Brown et al., 2009) and a number of items taken from the NHS staff survey relating to harassment and bullying (NHS staff survey coordination centre, 2018). The questionnaire required a response to all questions therefore questionnaires did not have missing items and incomplete questionnaires were screened out.

Demographic Survey

The demographic questionnaire collected the following information: profession, type of contract, years since professional qualification, years worked since qualification, years in current post, contracted hours, additional paid and unpaid hours, type of organisation, pay scale, gender, sexual orientation, ethnicity, illness/disability and age. The illness/disability question asked *'Do you have a long-standing illness or disability?'*

The Psychological Practitioner Workplace Wellbeing Measure (PPWWM)

The PPWWM is a 26-item Likert scale (1 *strongly disagree* to 5 *strongly agree*) with a score range of 26 to 130. Higher scores indicate greater wellbeing. It was validated with a sample of 400 psychological practitioners (Summers et al., 2020) and showed good construct validity against: a generic workplace wellbeing measure, The Health and Safety Executive Management Standards Indicator Tool (Health and Safety Executive, 2004) $r=.88$; The Satisfaction with Life Scale (Diener et al., 1985) $r=.50$; The General Health Questionnaire (12) (Goldberg, 1992) $r=-.31$. Test-retest reliability and internal consistency were $r=.94$ and $\alpha=.92$, respectively. The PPWWM produced a six-factor structure: 'professional and organisational satisfaction', 'support and flexibility', 'professional role', 'physical environment', 'clinical supervision' and 'external personal' support.

Short Warwick-Edinburgh Mental Well-being Scale

The Short Warwick-Edinburgh Mental Well-being Scale (SWEMWEBS) (Stewart-Brown et al., 2009) is a unidimensional self-report, 7-item scale using a 5-point rating system (1 *none of the time* to 5 *all of the time*) to assess mental-wellbeing. It was derived from the original 14-item Warwick-Edinburgh Mental Well-being Scale (WEMWEBS) (Tennant et al., 2007). Its score range is 7 to 35 with higher scores indicating greater wellbeing. The WEMWEBS was developed using Rasch analysis (Stewart-Brown et al., 2009) to measure wellbeing in the general population and for the evaluation of projects and policies that aim to improve mental wellbeing. It has been widely used within the UK in population surveys (for example, Bellis, Lowey, Leckenby, Hughes & Harrison, 2013) and for the assessment of

interventions to improve mental wellbeing (for example, Shah, Cader, Andrews, Wijesekera, & Stewart-Brown, 2018). Cronbach's α for the SWEMWBS was .84 (Fat, Scholes, Boniface, Mindell & Stewart-Brown, 2017), indicating high internal consistency (DeVellis, 2017). The test-retest reliability has not been evaluated. The SWEMWBS is negatively correlated with the GHQ-12 and positively correlated with happiness and positive health state (Ng Fat et al., 2017).

Additional items

Nine additional quantitative items from the National Health Service (UK) staff survey (NHS staff survey coordination centre, 2018) were included. These tapped harassment, bullying and discrimination at work, organisational change, staffing levels and overall mood. Participants were also given the opportunity to provide additional comments within a 'free-text' format relating to their wellbeing and the survey questions.

Data Cleaning and Analysis

As noted above, the forced choice nature of the questionnaire did not generate missing questions. Data were cleaned by removing any incomplete questionnaires and responses from participants who did not meet the inclusion criteria.

Data analysis used IBM SPSS® version 25. All correlations and ANOVA analyses used bootstrapping (2000 iterations) to give a more robust test with respect to deviation from assumptions. Bonferroni corrections for analyses involving demographic variables were not made because they are highly conservative and can fail to identify significant relationships in survey research (Bland & Altman, 1996). Commentaries suggest there is a lack of consensus as to how Bonferroni should be applied (Drezner & Drezner, 2016) and that their routine use should be avoided (Armstrong, 2014). To counter Type 1 errors comparisons were made with Summers et al. (2020) to establish replicability.

The comparisons of the SWEMWBS with the survey of Ng Fat et al (2017) used a one-sample t-test. The significance of PPWWM distribution skew and kurtosis was evaluated using their standard errors to obtain a z-statistic. One-way ANOVA was used to compare the PPWWM and SWEMWBS scores across sub-groups and follow-up tests were two-tailed one-sample t-tests comparing subgroup means with the overall mean. Pearson correlation with bootstrapping was used to measure associations between interval variables (e.g. PPWWM and SWEMWBS).

Key demographic variables such as age and salary were reported separately for males and females.

The Factor analysis used a Varimax rotation of the principal components matrix with rotation of factors with Eigen values >1.

Results

Key demographic variables are presented separately for males and females in Table 2 together with statistical comparisons and further demographic data appears in Table 3.

Table 2 about here

For the total sample of 1,678 the means for the PPWWM and the SWEMWBS were 91.88 ($SD = 17.55$) and 22.21 ($SD = 3.92$) respectively and the inter-correlation was $r = .61$; $p < .0001$. The mean wellbeing score for the SWEMWBS in this sample were 22.09 for men and 22.24 for women compared with 23.70 and 23.20 in a national UK survey (Ng Fat et al., 2017). These scores were significantly below those of the national survey; $t = -7.22$; $df = 319$; $p < .001$ and $t = -9.05$; $df = 1333$; $p < .001$, respectively.

The PPWWM distribution was approximately normal with non-significant skew (-0.05) but there was negative kurtosis (-0.45, $p < 0.01$). (Figure 1.) Significance of deviation from normality is not uncommon in very large samples that can detect small effects, and a Q-Q plot showed good conformity to the normal distribution apart from lower than expected values at the extreme lower end of the scale.

Figure 1 about here

Means of the PPWWM and SWEMWBS for subgroups with 15 or more respondents are given in Table 3. Post-hoc subgroup follow-up tests comparing groups to the overall mean were completed when the overall ANOVA was significant. All post-hoc follow-up t-tests were two-tailed.

Table 3 about here

For professional groups a one-way ANOVA showed that there were significant differences across all groups for the PPWWM ($F_{(10,1667)} = 2.89$; $p < .001$) and the SWEMWBS ($F_{(10,1667)} = 2.90$; $p < .001$). For the PPWWM assistant psychologists, psychological wellbeing practitioner wellbeing and counsellors scored significantly higher than the overall mean ($t = -2.16$, $df = 23$; $p = .042$, $t = 2.47$, $df = 225$; $p = .018$ and $t = 2.22$, $df = 94$; $p = .029$). But for the SWEMWBS trainee clinical psychologists and assistant psychologists showed lower than average general wellbeing ($t = -3.10$, $df = 27$; $p = .007$ and $t = -2.12$, $df = 23$; $p = .039$). While psychological wellbeing practitioners had higher than average general wellbeing ($t = 2.91$, $df = 225$; $p = .006$).

There was also a significant effect of type of contract (PPWWM, $F_{(3,1674)} = 7.27$; $p < .0001$: SWEMWBS, $F_{(3,1674)} = 6.99$; $p < .0001$). Self-employed practitioners and those on non-

permanent contracts demonstrated above average PPWWM scores ($t = 2.91$, $df = 18$; $p = .009$, two-tailed; $t = 3.70$, $df = 188$; $p < .001$, two-tailed) while those on permanent contracts were below the mean, but not significantly so.

Only the self-employed/private practice/independent group differed significantly from the mean on the SWEMBS ($t = 3.85$, $df = 18$; $p = .003$).

For sector of employment the differences were significant for the PPWWM ($F_{(5,1672)} = 4.79$; $p < .0001$) but not for the SWEMWBS ($F_{(5,1672)} = 2.05$; $p = .069$). Follow-up tests for the PPWWM showed that only private organisation/independent workers ($t = 2.39$, $df = 55$; $p = .025$) and third sector /charitable organisation workers ($t = 4.43$, $df = 71$; $p < .001$) scored above the overall mean.

Gender differences for the PPWWM and SWEMWBS were not statistically significant. Similarly, there were no statistical differences for sexual orientation.

The overall differences between ethnic groups were statistically significant (PPWWM, $F_{(4,1617)} = 2.89$; $p < .021$; SWEMWBS, $F_{(4,1617)} = 3.82$; $p < .004$). For the PPWWM and SWEMBS Asian groups were above the mean ($t = 2.18$, $df = 65$; $p = .042$ and $t = 2.0$, $df = 65$; $p = .048$). No other group differences were significant.

Those reporting disabilities (17.1% of the sample) had significantly lower wellbeing on the PPWWM and the SWEMWBS (PPWWM, $F_{(1,1630)} = 16.13$; $p < .0001$; SWEMWBS, $F_{(1,1630)} = 19.55$; $p < .0001$).

Correlations for key variables with the PPWWM are shown in Table 4. Noteworthy associations are those with the questions about experiences of harassment, especially by managers (19.0% reported experiencing harassment or bullying), feeling depressed (43.3% reported feeling depressed '*some of the time*' or '*often*') or a failure (42.3% reported feeling a failure '*some of the time*' or '*often*') and wanting to leave the NHS (74.7% reported wanting to leave '*at least once or twice a year*'). Although not large, there were significant *negative* correlations with age and pay scale and with years served in the current post.

Table 4 about here

Table 5 depicts the Varimax structure matrix for the factor analysis of the PPWWM. Factors with Eigen vales >1 gave a five factor solution.

Table 5 about here

Discussion

The current sample PPWWM mean and standard deviation of 91.88 (SD=17.55) and Cronbach's Alpha of .92 correspond with the results of the validation study (Summers et al., 2020) which were 93.47(17.67) and .92. The means did not differ significantly between the two studies. The PPWWM distribution had significant negative kurtosis, as also found by Summers et al. (2020) but in this case there was no significant skew. The large sample size made it possible to detect statistical significance of minor deviations from normality. But the Q-Q plot showed good conformity to the normal distribution suggesting that the deviation is trivial. The mean scores for the SWEMWBS were below the UK norms for men and women (Ng Fat et al., 2017) suggesting that this professional group experience reduced wellbeing compared to the general population. This corroborates the previous literature on burnout and distress (Table 1).

The small, but significant, *negative* correlations with age, years since qualification and pay scale (Table 4) were not expected. In this profession at least, it appears that higher pay is not associated with improved workplace wellbeing. This small negative association with age and age-related variables replicates the results of Summers et al. (2020). While it is important not to over-interpret these small negative correlations, these findings do contrast with results from the USA and Australia demonstrating significantly *higher* scores on indices of burnout in younger, less experienced psychologists (Dorociak, Patricia, Rupert and Zahniser, 2017; Ackerley, Burnell, Holder & Kurdek, 1988; Rupert & Kent, 2007; Rupert & Morgan, 2005; Rupert, Stevanovic & Hunley, 2009; D'Souza, Egan & Rees. 2011; Di Benedetto & Swadling, 2014). There may be two reasons for this. First, the results may be culture-specific. All these studies were cross-sectional. The specific experiences of older cohorts in the UK may have detruded their workplace well-being, possibly as a result of the re-structuring of public health service pay and conditions between 2004 and 2007 and the erosion of pensions from 2008 onwards. Second, the PPWWM measured positive aspects of workplace well-being as well as the negative aspects (burnout) measured in the USA and Australian studies. Possibly the positive and negative aspects of wellbeing have different longitudinal trajectories.

The PPWWM and the SWEMWBS scores differed significantly between professional subgroups. This effect for the PPWWM was not observed by Summers et al. (2020), but their sample was much less heterogeneous with over 73% being clinical psychologists compared with 49% in this sample. Psychological wellbeing practitioners were above the mean on both measure and counsellors were above the mean on the PPWWM. Meanwhile trainee psychologists and assistant psychologists reported the highest group average scores on the PPWWM and the lowest average scores on the SWEMWBS. For assistant psychologists differences from the overall mean were significant on both measures; for

trainee psychologists the differences were significant only for the SWEMWBS. These groups are both on the usual pathway to qualifying as clinical psychologists. Perhaps hopeful career anticipation elevated the workplace wellbeing score while other factors, such as the need to relocate and make personal sacrifices for career, detruded general wellbeing. This decoupling between general wellbeing and workplace wellbeing highlights the importance of using specific measures to evaluate workplace wellbeing.

Staff on non-permanent contracts were above the mean for the PPWWM and self-employed and private practitioners were above the mean on both the PPWWM and the SWEMWBS. It was unexpected that those on fixed term and temporary contracts and the self-employed/private group would demonstrate higher workplace wellbeing scores than those on permanent organisational contracts. A review of studies of workers on temporary contracts (De Kuyper & De Witte, 2009) also concluded temporary contracts were not associated with poor outcomes and there was some evidence for better wellbeing in temporary workers. This result also replicates Summers et al. (2020) and seems to be a robust finding. It may be because the temporary contract group contains more early career staff who exhibit high workplace wellbeing.

The private sector/independent sector group and the third sector/charitable group both had averages above the overall mean for the PPWWM. This was not found by Summers et al. (2020) where nearly 90% of the sample were wholly employed by the NHS. It is concerning that NHS employees were not in this elevated category and this concern is reflected by reports of poor staff wellbeing in large healthcare organisations such as the UK NHS (Health Education England, 2019).

Wellbeing did not differ across genders nor across those with different sexual orientations. This absence of gender difference is consistent with the finding of Summers et al. (2020).

Recently there has been considerable interest in gender difference in pay and career progression (Office for National Statistics, 2019). This sample did show a small gender difference in favour of males in Agenda for Change banding of NHS workers (Table 2). However, male workers in this sample were on average older and had worked more years since qualification than the females and both these factors were highly associated with salary. This is not to say that female workers do not experience disadvantage in the workforce since 'the motherhood penalty', for example, has the potential to create inequalities in both years worked and age when leaving the workforce (Chung, Graham, Downs, Sandler & Sienkiewicz 2017).

Ethnicity showed an overall statistical difference for PPWWM scores with those identifying as Asian (other than Chinese) having a significantly higher than average score on both measures and those identifying as mixed race having the lowest scores on both measures (but not significantly so). Lower wellbeing in black and minority ethnic people is well documented (Stevenson & Rao, 2014), but the current study revealed a mixed picture for

psychological practitioners with white practitioners demonstrating somewhat lower wellbeing than all groups other than those of mixed race. However, sample sizes for the non-white groups are small, so differences should be treated with caution.

The percentage of psychological practitioners self-identifying as disabled (over 17%) was unexpected; it was only 12% in Summers et al.'s (2020) mainly clinical psychologist sample. However, this figure is close to that of the 2018 NHS staff survey figure of 18% (NHS staff survey coordination centre, 2018). There was a very clear and highly significant difference between those reporting disabilities and those who did not in terms of workplace wellbeing and general wellbeing in favour of those without reported disability. This reflects the negative relationship between job satisfaction and long-term health problems/disabilities (Gazioglu & Tansel, 2006; Clark, 1996) and indicates the need for improved understanding of workplace support for workers with disabilities (Nevala, Pehkonen, Koskela, Ruusuvuori, & Anttila, 2015).

Self-reported '*feeling depressed*' (43.3%) and '*a failure*' (42.3%) was comparable with the survey of Hacker-Hughes et al., (2016) who reported 48%. The correlations of these indices with the PPWWM are indicative of the negative aspects of workplace wellbeing. This relationship with depression was expected and reflects the findings of copious previous research (Glass & McKnight, 1996). However, the functional relationship between depression and burnout remains unclear, especially the question of whether they are aspects of the same phenomenon or different stages in a developmental sequence (Bianchi, Shonfeld & Laurent, 2015).

Self-reported harassment and bullying also correlated with the PPWWM. This finding corroborates previous cross-sectional and longitudinal work on the relationship between bullying and harassment and psychological and physical symptoms (Beswick, Gore, Palferman, 2006).

Finally, the negative association between the PPWWM and wanting to leave the NHS is indicative of the potential for factors associated with poor workforce wellbeing to engender high staff turnover rates (Boorman, 2009; Griffeth, Hom & Gaertner, 2000). This highlights the importance of interventions to promote wellbeing as a means of reducing unplanned absences and the costs associated with high turnover (Michie & Williams, 2003).

The factor structure of the PPWWM in this study differed somewhat from that of the validation study. There may be several reasons for this. The sample was larger and more diverse in terms of professional groups. Also, the PPWWM is designed to be a brief questionnaire which necessarily reduces the number of items per factor and this in turn reduces factorial stability (Costello & Osborne, 2005; Field, 2018). However, the differences

that did emerge are explicable. For example, the Supervision Factor, a separate two-item factor in the validation study, was subsumed under the Support and Flexibility Factor in the present study which affirms the supportive nature of supervision. Two items (21 & 22, about organisational support for personal development) from the Professional and Organisational Satisfaction Factor of the validation study loaded equally on the satisfaction and support factors in this study. Since they referred to support, they were included under this factor, but clearly also have an association with organisational satisfaction. The Professional Role Factor in the present study encompassed three items (Item 2 & 6, referencing support from colleagues and Item 4, referencing sense of belonging) from the Support and Flexibility Factor in the validation study. Again, colleague support and belonging could equally be perceived as an aspect of professional role. Finally, Item 1, which referred to having someone to turn to, was originally under the External Personal Factor, but in the current study was under the Support and Flexibility Factor.

Limitations and Further Research

Although large, the sample may not have been representative. It was a volunteer sample and included less than 10% of the total number of qualified clinical psychologists and probably about the same percentage of the total psychological practitioner workforce of the UK. Moreover, numbers in some of the subgroups were relatively small which limited the dependability of inter-group comparisons.

The PPWWM measures positive and negative aspects of workplace wellbeing. The positive aspects explain the correlation with the SWEMWBS measure of general wellbeing. But it would have been useful to also have a general measure of distress to confirm the relationship with the negative aspects of workplace wellbeing. The temporal stability (test-re-test reliability) of the SWEMWS has yet to be established. Until this is established, the effect on correlations of error due to temporal factors cannot be quantified.

Surveys of this kind require large numbers of comparisons that inflate Type 1 error rates. Bonferroni correction can correct for this, but as noted earlier, they are highly conservative and inflate Type 2 error rates. An alternative approach is to demonstrate dependability of significant results through replication over successive surveys, as here.

These results suggest several areas of future research. It would strengthen confidence in the associations between factors and workplace wellbeing if they were evaluated longitudinally. Longitudinal research could also shed light on the functional relationship between positive and negative aspects of workplace wellbeing (including depression and burnout) and whether they exert mutual influence over time. It could also be helpful in explaining the cross-cultural variation in the relationship between workplace wellbeing and age. Another question that requires clarification stems from by the inverse relationship between workplace wellbeing and general wellbeing in some early career groups. Finally,

the particularly low wellbeing people who report disabilities urgently requires further investigation.

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Table 1 Studies of burnout in psychological practitioners

Authors (year) <i>Country of study</i>	Sample size (% response rate)	Profession (%)	Years of experience	Burnout measure	Main Conclusion
Ackerley et al. (1988) <i>USA</i>	562 (35.4)	Licensed psychologists (100)	<i>M</i> = 18.8 years Range = 1-43	MBI (1986)	Each MBI subscale showed higher burnout than the norms for mental health workers. 'High burnout' threshold exceeded on EE & DP scales for over 1/3 of the sample
Berjot et al. (2017) <i>France</i>	664 (NR)	Professional psychologists (100)	<i>M</i> = 8.01	French- Canadian version MBI-HSS (Maslach et al., 1996) French translation (Dion & Tessier, 1994)	Over 60% over cut-off for burnout on EE & DP scales
Di Benedetto & Swadling (2014) <i>Australia</i>	167 (NR)	Registered psychologists (100)	NR	CBI (Kristensen et al., 2005)	14.4% above threshold for burnout on the overall score. Burnout negatively correlated with experience.
D'Souza et al. (2011) <i>Australia</i>	87 (NR)	Clinical psychologists (100)	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)	8% above threshold for burnout on overall score. Average of all three scales above burnout threshold Negative correlation with age.
Emery et al. (2009) <i>Australia</i>	190 (39)	Clinical psychologists (100)	< 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)	Only the PA scale average was above burnout threshold. No association with age.
Rupert & Kent (2007) <i>USA</i>	595 (49.6)	Clinical psychologists (83.2) Counselling psychologists (16.8)	<i>M</i> = 17.91 <i>SD</i> = 8.07	MBI-HSS (Maslach et al., 1996)	Overall mean was in average burnout range for EE & DP scales, low for PA scale. Negative correlation with age.
Rupert & Morgan (2005) <i>USA</i>	571 (47.6)	Clinical psychologists (80) Counselling psychologists (20)	<i>M</i> = 16.93 <i>SD</i> = 7.66	MBI-HSS (Maslach et al., 1996)	Average burnout on DP & EE scales, low on PA scale. Negative correlation with age.
Rupert et al. (2009) <i>USA</i>	487 (40.58)	Licensed psychologists (100)	<i>M</i> = 19.6 <i>SD</i> = 7.8	MBI-HSS (Maslach et al., 1996)	Average burnout on DP & EE scales, low on PA scale. Negative correlation with age.

Table 2 Demographic data by gender

	Male		Female	
	Count	%	Count	%
Age by gender**				
18 - 24	2	0.6%	27	2.0%
25 - 34	58	18.1%	401	30.1%
35 - 44	93	29.1%	377	28.3%
45 - 54	100	31.3%	354	26.5%
55 - 64	55	17.2%	145	10.9%
65 - 74	10	3.1%	19	1.4%
75 or older	0	0.0%	0	0.0%
Undisclosed	2	0.6%	11	0.8%
**Kruskal-Wallis Test, p<.000				
Contract type by gender				
Permanent/ Open ended	272	85.0%	1141	85.5%
Non-permanent/ Fixed-term/ Secondment	32	10.0%	154	11.5%
Self Employed/ Private Practice/ Independent	5	1.6%	14	1.0%
Other	11	3.4%	25	1.9%
Agenda for Change salary by gender*				
Band 3	2	0.7%	3	0.2%
Band 4	8	2.7%	49	3.9%
Band 5	23	7.7%	152	12.0%
Band 6	30	10.0%	157	12.4%
Band 7	92	30.8%	315	24.9%
Band 8a	54	18.1%	286	22.6%
Band 8b	27	9.0%	109	8.6%
Band 8c	35	11.7%	136	10.7%
Band 8d	18	6.0%	42	3.3%
Band 9	5	1.7%	6	0.5%
Do not wish to disclose	5	1.7%	12	0.9%
*Kruskal-Wallis Test, p=.03				
Years worked since qualified by gender**				
Up to 5 years	88	27.5%	515	38.6%
5 - 10 years	79	24.7%	308	23.1%
11 - 15 years	50	15.6%	198	14.8%
16 - 20 years	40	12.5%	127	9.5%
21 - 25 years	24	7.5%	82	6.1%
26 - 30 years	16	5.0%	56	4.2%
31 - 35 years	10	3.1%	32	2.4%
36 years or more	13	4.1%	16	1.2%
**Kruskal-Wallis Test, p<.000				

Table 3 PPWWM means by group

	CATEGORY	N(%) [†]	PPWWM Mean(SD)	SWEMWBS Mean(SD)
PROFESSIONAL GROUP	Clinical Psychologist	814(49)	90.85(16.57)	22.08(3.36)
	Counselling Psychologist	39(2)	92.05(20.70)	22.97(4.34)
	High Intensity Therapist	152(9)	89.11(19.96)	21.69(4.77)
	Psychological Wellbeing Practitioner	226(13)	94.88(18.22)*	23.11(4.64)**
	Counsellor	95(6)	95.66(16.59)*	22.88(3.81)
	Cognitive Behaviour Therapist	148(9)	91.25(18.52)	22.07(4.07)
	Psychotherapist	42(3)	91.05(18.15)	22.58(4.71)
	Trainee Clinical Psychologist	28(2)	96.11(14.84)	20.54(2.86)**
	Nurse/Mental Health Nurse	20(1)	92.80(16.46)	22.13(4.39)
	Assistant Psychologist	24(1)	102.58(15.51)*	20.88(3.02)*
	Other	90(5)	91.29(17.34)	21.92(4.26)
Total	1678	91.88(17.55)***	22.21(3.92)***	
CONTRACT	Permanent/ Open ended	1434(85)	91.21(17.67)	22.19 (3.97)
	Non-permanent/ Fixed-term/ Secondment	189(11)	95.99(15.29)***	21.79(3.25)
	Self Employed/ Private Practice/ Independent	19(1)	103.84(17.92)**	25.66(3.90)**
	Other	36(2)	90.33(19.02)	23.48 (4.16)
Total	1678	91.88(17.55)***	22.21(3.92)***	
SECTOR	NHS	1471(88)	91.20(17.61)	22.10(3.97)
	Private organisation/ Independent	56(3)	97.20(16.64)*	23.09(3.10)
	Third sector/ Charitable organisation	72(4)	99.82(15.21)**	23.12(4.09)
	Equal NHS and non-NHS	22(1)	92.09(17.43)	22.71(2.95)
	Education	17(1)	97.00(16.64)	23.17(2.51)
	Other	40(2)	92.90(16.71)	22.81(3.31)
Total	1678	91.88(17.55)***	22.21(3.92)	
GENDER	Male	320(19)	92.10(17.83)	22.09(3.99)
	Female	1334(81)	91.86(17.35)	22.24(3.89)
	Total	1654	91.91(17.44)	22.21(3.91)
SEX ORIENTATION	Heterosexual	1412(89)	92.06(17.50)	22.29(3.91)
	Bisexual	81(5)	92.75(15.51)	21.07(3.41)
	Lesbian/Gay/Queer	93(6)	92.89(18.55)	22.29(4.79)
	Total	1586	92.14(17.46)	22.23(3.95)
ETHNICITY	Asian or Asian British (Bangladeshi/ Indian/ Pakistani/ Any other Asian)	66(4)	97.26(20.08)*	23.21(4.08)*
	Black or Black British (African/ Caribbean/ Any other Black)	40(2)	94.28(23.10)	24.01(6.02)
	Mixed (Any mixed ethnicity)	51(3)	87.14(18.71)	22.00(4.47)
	White (British/ Irish/ Any other White ethnicity)	1440(89)	91.79(17.03)	22.11(3.81)
	Other ethnic group (Chinese/ Any other)	25(2)	94.80(18.06)	23.16 (4.44)
Total	1622	91.97(17.45)*	22.21(3.93)**	
DISABILITY	Report Disability	279(17)	88.24(17.08)	21.23 (3.75)
	No Report of Disability	1353(83)	92.82(17.38)	22.41(3.91)

Total

1632 92.04(17.41)* 22.21(3.91)*****

[†] Based on the number answering the question

* $p < .05$; ** $p < .01$; *** $p < .001$: For subgroups the p-values refer to differences from the overall mean.

Table 4 Significant correlations of key variables with PPWWM

Variable	Correlation [†]	N
Additional unpaid hours on average per week	<i>Tau-b</i> = -.189***	1656
How often in the past month have you wanted to leave the NHS	<i>Tau-b</i> = -.511***	1455
Age	<i>Tau-b</i> = -.043*	1678
Agenda for Change Band	<i>Tau-b</i> = -.036*	1678
Years served in current post	<i>Tau-b</i> = -.075***	1590
Number of years since qualifying	<i>Tau-b</i> = -.041*	1678
Harassment or bullying—Service Users/Public	<i>Tau-b</i> = -.147***	1678
Harassment or bullying—Managers	<i>Tau-b</i> = -.319***	1678
Harassment or bullying—Colleagues	<i>Tau-b</i> = -.165***	1678
Time in past week felt depressed	<i>Tau-b</i> = -.400***	1678
Time in the past week felt a failure	<i>Tau-b</i> = -.352***	1678

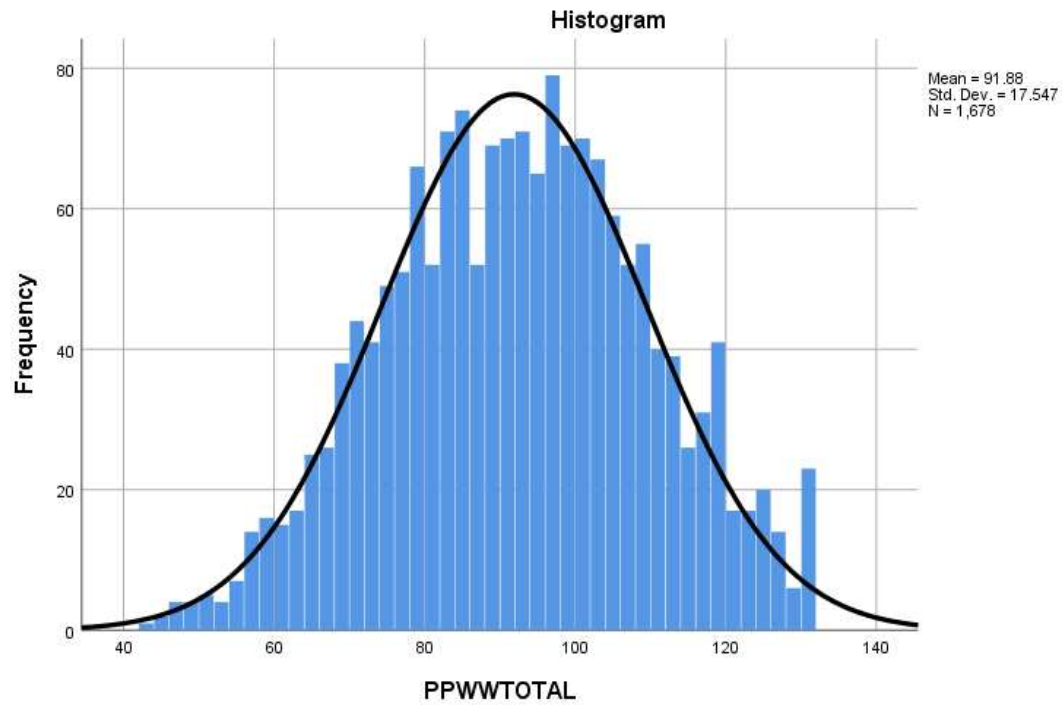
[†] All correlations used bootstrapping with 2000 iterations and were two-tailed.

* $p < .05$ *** $p < .0001$

Table 5 Factor Structure

Item	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	PPWWM Dimension / Construct
Factor 1: Professional and organisational satisfaction						
7. I feel I can balance less fulfilling aspects of my job with more enjoyable aspects	.43	.25	.38	.33	.12	Positive and negative job aspects/Work control and autonomy
8. I cannot see how the service/ organisation in which I work can ever be delivered effectively	.64	.06	.13	.13	.17	Organisational context/Organisational hopefulness-hopelessness
10. I am enabled to manage and organise my workload and diary	.40	.37	.18	.37	-.05	Positive and negative job aspects/Work control and autonomy
12. I feel confident the service/ organisation in which I work can adapt to meet future service demands	.66	.21	.16	.18	.16	Organisational context/Organisational hopefulness-hopelessness
18. I do not feel included in service/ organisational decisions that affect me	.59	.12	.21	-.08	.13	Organisational context/Organisational engagement
23. I am expected to reach unrealistic or unattainable targets	.64	.21	.06	.26	.14	Organisational context/Organisational targets
25. I feel service/ organisational targets are meaningful	.71	.09	.14	.14	.15	Organisational context/Organisational targets
Factor 2: Support and flexibility						
1. I do not feel there is always someone there for me when I need personal support	.15	.43	.24	.17	.15	Personal support-lack of support/Family support
4. Flexible working arrangements are supported in my service/organisation	.34	.37	.26	-.11	-.08	Positive and negative job aspects /Work-life balance
5. I feel supported by my line-manager to take positive risks without fear of reproach	.38	.60	.30	-.08	-.02	Personal support-lack of support/Line management
9. The clinical supervision I receive is containing and safe	.00	.78	.11	.27	.19	Personal support-lack of support/Clinical supervision
13. Clinical supervision meets my support needs	.08	.75	.10	.35	.22	Personal support-lack of support/Clinical supervision
20. My line-manager is approachable and responsive	.24	.62	.31	-.04	-.01	Personal support-lack of support/Management
21. My continuing professional development needs are supported	.50	.50	.15	-.03	.07	Positive and negative job aspects/Opportunities to learn
22. I am encouraged and supported to develop my skill-set and knowledge	.53	.53	.22	-.04	.09	Positive and negative job aspects/Opportunities to learn
Factor 3: Professional Role						
2. I feel I can seek support from my colleagues	-.01	.35	.68	.09	.11	Personal support-lack of support/Colleagues
3. I feel a sense of belonging to the service/ organisation in which I work	.40	.25	.59	-.02	.12	Organisational context/Organisational engagement
6. I work in an environment where my colleagues are caring and supportive towards each other	.06	.32	.70	.05	.12	Personal support-lack of support/Colleagues
11. I am clear of my role in relation to other professionals with whom I work	.32	.13	.47	.25	.01	Inter-professional Agents/Role clarity
14. My colleagues have realistic expectations of my professional role	.33	.23	.50	.31	.15	Inter-professional Agents/Role clarity
16. My colleagues value my professional contribution	.14	.12	.73	.19	.12	Positive and negative job aspects /Feeling valued
26 My specific skills as a psychological practitioner add value to the team/ service/ organisation	.25	.01	.55	.18	-.02	Positive and negative job aspects /Feeling valued
Factor 4: Physical Environment						
15. The physical environment and facilities in my workplace enable me to work efficiently and effectively	.30	.17	.19	.08	.81	Positive and negative job aspects /Physical environment and facilities
24. The physical environment and/ or facilities in my workplace adversely affect my workplace wellbeing	.26	.13	.11	.07	.85	Positive and negative job aspects /Physical environment and facilities
Factor 5: External Personal						
17. I have a good work/ life balance	.29	.15	.20	.65	.04	Positive and negative job aspects /Work-life balance
19. The personal support I receive from family and/or friends meets my needs	-.00	.03	.17	.71	.07	Personal support-lack of support/Family support

Figure 1. Distribution of the PPWWM



Note: Can be printed in grey-scale

