Camaraderie, cuts, and COVID-19: Factors affecting the wellbeing of NHS psychological therapists

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

This thesis examines factors impacting the wellbeing of NHS psychological therapists and how they seek support with these.

Part 1 is a systematic review of literature investigating organisational factors which contribute to or protect against the experience of burnout in psychological therapists. For the review period of 2013 to 2023, 15 studies were identified and their results are presented as a narrative synthesis. Excessive job demands, pressure from organisations, and conflict with colleagues were identified as particular risks for burnout. Supportive collegial relationships and high-quality supervision were identified as protective against burnout. More research is needed to understand stressors which therapists perceive to be particularly demanding, and what therapists find particularly useful about collegial and supervisory relationships.

Part 2 is an empirical study of factors which impact the wellbeing of psychological therapists, which sources of support they most value, and any barriers to accessing these. Additionally, there is a focus on the impact of working throughout the COVID-19 pandemic and the impact this has had on work-related wellbeing. Semi-structured interviews with 14 psychological therapists were analysed using thematic analysis. Themes identified included but were not limited to the impact of therapeutic work itself, the challenges of working in an underfunded healthcare system, and the value of support from colleagues, supervisors, and management.

Part 3 is a critical appraisal of the research process. It contains reflections on the inspiration for the research topic, challenges encountered during the research process, and reflections on being an 'insider' researcher with regards to the topic chosen.

Impact Statement

The National Health Service (NHS) is currently experiencing a crisis of retention (Ratwatte, 2023). Despite investing in the training routes of many healthcare professionals, many professionals are leaving the organisation and there are extensive vacancies across all sectors, particularly mental health roles (NHS Vacancy Statistics, 2023). It is argued that this is the result of social and political forces over recent years, such as government policies, Brexit, and the COVID-19 pandemic, which have detrimentally impacted working conditions. Psychological therapists are understood to be a staff group particularly vulnerable to impaired wellbeing at work due to high emotional demands and exposure to distress, trauma, and risk from their work with service users. It is therefore essential to understand what factors most significantly impact their wellbeing, what sources of support they most value, and how accessible these sources of support are to improve working conditions where possible. Given current strike action over working conditions by some NHS professional groups, this research is particularly topical.

Part 1 notes the high levels of burnout in psychological therapists, and investigates organisational factors which are associated with therapist experience of burnout. Although there is existing evidence about individual factors associated with burnout, such as demographic factors and personality constructs, organisational factors have more potential to be malleable. Therefore, it is essential to understand what organisational factors contribute to burnout, and which can be protective. The results of this review can inform organisations who employ psychological therapists regarding key areas in which to focus their efforts to best support their employees. Furthermore, the results of this review highlight gaps in the existing literature around therapist experience of burnout and indicate where further research is needed.

Part 2 focuses directly on the experience of NHS psychological therapists. It provides up-to-date insights about therapist wellbeing in light of the significant pressures upon and changes to the NHS since the COVID-19 pandemic. This study benefits from including diverse viewpoints from therapists across various regions of the UK and in various roles. It highlights demands at work that therapists find particularly stressful or rewarding, in addition to most valued sources of support and barriers to accessing these. It also highlights where investment in certain organisational wellbeing initiatives can potentially be improved. These findings are timely given the current socio-political climate and the discourse around NHS working conditions and high vacancies in psychology roles (Palmer et al., 2017). The findings provide valuable insights into better understanding the pressures on therapists and how best to support them. Given the large financial investment from the NHS that goes into their training, it is essential to improve working conditions for therapists in order to retain them within the organisation. This research provides evidence of where to target these efforts.

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Part 1: Literature Review

Organisational factors which impact experience of burnout in psychological therapists

Abstract

Aims: Burnout refers to the physical and psychological impact on an employee when chronic demands from their work overwhelm their personal resources to cope. This results in emotional exhaustion, cynicism and disengagement from work, and a decreased sense of personal accomplishment. Healthcare professionals have been found to be particularly vulnerable to burnout, however, there is relatively little literature focussing on psychological therapists. This is despite research which indicates therapists may have a unique relationship to burnout due to high emotional demands of their job.

Methods: A systematic search of four databases (PsycINFO, Medline, EMCARE, and CINAHL) was conducted to retrieve qualitative and quantitative literature which examined the relationship between organisational factors and the experience of burnout in psychological therapists.

Results: Fifteen empirical studies were identified which met inclusion criteria. A narrative synthesis of these studies identified five key organisational factors which contribute to or protect against burnout; job demands, colleague relationships, supervision, organisational culture, and employment issues. Perceived high job demands, pressure from one's employing organisation, and conflict with colleagues contributed to burnout. Supportive collegial relationships and high-quality supervisory relationships were identified as protective against burnout.

Conclusions: This review highlights key areas on which organisations should focus to maximise supportive working environments, to maintain the welfare of their employees and maximise outcomes for their service users. However, further research is needed to understand particular stressors which therapists perceive to be particularly demanding, under what circumstances therapists seek certain types of support, and what barriers may persist to therapists seeking help.

Introduction

'Burnout' refers to the psychological and physical impact on an individual of a state in which the chronic demands of their professional role exceed their personal resources. The phenomenon of burnout was first discussed in academic literature by Freudenberger (1974). In this paper, the author described a number of symptoms that affect the individual's temperament, behaviour, and physical health. These include feelings of physical exhaustion, headaches, gastrointestinal issues, impaired sleep, feeling overwhelmed, negative attitude, low mood, frustration, more risk-taking behaviours in one's work, and impaired relationships with colleagues. As research in this area has progressed, burnout is now generally understood as a phenomenon with three main dimensions: emotional exhaustion, depersonalisation, and reduced personal accomplishment (Maslach & Jackson, 1981). Emotional exhaustion is understood as more than just a physical feeling of fatigue, but rather as both a chronic physical and psychological experience in which the individual feels depleted. Depersonalisation, also sometimes referred to as cynicism, refers to the individual psychologically detaching from their work and developing a negative, cynical, or hostile attitude towards it. Reduced personal accomplishment describes the individual losing their sense of achievement in their work, and possibly also becoming less competent and productive (Dewa et al, 2014; Nicola et al, 2015; Soroush et al., 2016). The three dimensions appear to be interlinked; depersonalisation is argued to be a psychological defence mechanism to protect the individual from continued emotional arousal which would further deplete the already exhausted worker (Maslach et al., 2001). An individual who is feeling overwhelmed, fatigued, and feels cynical or indifferent to their work is unlikely to feel productive and engaged in it, and is therefore unlikely to experience feelings of achievement and self-efficacy. Maslach & Leiter (2016) further developed understanding of burnout by identifying six crucial areas of working life which can contribute to burnout, or conversely

support an individual to positively engage with their work. These six factors are: workload; control; reward; community; fairness; and values. Using reward as an example, individuals are more likely to feel satisfied with and engaged in their job if they feel they are sufficiently renumerated for their labour, and their work is met with positive feedback. Conversely, individuals who feel underpaid or do not receive positive feedback are less likely to feel their work is properly valued and are thus more vulnerable to burnout.

The most commonly used method of measuring burnout is the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981). The first iteration of this measure is known as the MBI-Human Services Survey (MBI-HSS; Maslach et al., 1996) and was designed to measure burnout in healthcare professionals. Subsequently, Maslach and colleagues developed the MBI-Educators Survey (MBI-ES; Maslach et al., 1996), and then the MBI-General Survey (MBI-GS; Maslach et al., 1996), a version of the MBI for all workers. All iterations of the MBI measure the three aforementioned dimensions of burnout. However, there are other validated measures of burnout which take a different focus, for example the Oldenburg Burnout Inventory (OLBI; Demerouti et al., 2003; Demerouti & Baker, 2008), which considers just exhaustion and cynicism, and Copenhagen Burnout Inventory (CBI; Kristensen et al., 2005), which measures work-related, client-related, and personal burnout.

Early papers regarding burnout described the phenomenon in relation to healthcare professionals, however this has since been expanded and burnout is now understood as something which can impact employees in any field. For a thorough review of the history of burnout research, see Maslach et al. (2001). Despite this, interest continues in understanding burnout in healthcare professionals whose work involves unique demands which make them particularly vulnerable to experiencing burnout. It is essential to understand burnout in healthcare professionals for a number of reasons. First, in terms of impact on the individual's health, burnout is associated with mental health difficulties, such as anxiety, depression, and

suicidality (Samuelsson et al., 1997; Shirom & Melamed, 2005), as well as a number of increased physical health risks. Burnout has been found to be associated with headaches, musculoskeletal and gastrointestinal issues, viral respiratory illnesses (Gorter et al., 2000), and both cardiovascular disease (Appels & Shouten, 1991; Hendrix et al., 1991; Melamed et al., 1992) and Type 2 diabetes (Strikwerda et al., 2021). Secondly, burnout is associated with decreased job satisfaction. A number of studies have found burnout not only affects the individual, but also has an impact on the organisation, being associated with poorer job performance, absenteeism, job turnover and incivility between colleagues (Dyrbye et al., 2019; Rahim & Cosby, 2016). A study of nurses found burnout was predictive of intention to leave a job (Leiter & Maslach, 2009). Finally, the presentation of burnout has a direct impact on those for whom healthcare professionals provide care. Good, effective patient care should be compassionate and patient-centred, which can be challenging for any healthcare professional who is feeling depleted and has entered a state of depersonalisation. When the healthcare professional is feeling detached from the value of their work, and is unable to empathise with their patients to their full capacity, patient care suffers. Indeed, a number of systematic reviews have found both quality and safety of patient care have negative relationships with levels of healthcare professional burnout (Hall et al., 2016; Salyers et al., 2016).

Despite the focus on burnout in healthcare professionals, especially among medics and nurses, there is comparatively little research investigating burnout in psychological therapists. The delivery of psychological therapy is emotionally intensive, and therapists are exposed to emotive content on a regular basis. Therapeutic relationships may be longer term than healthcare professional/patient relationships in medical settings, and involve more regular contact than in other healthcare settings. This work also involves high responsibility for the client's welfare, including potentially managing suicide and safeguarding risks. One

might expect therefore that psychological therapists are at high risk of burnout as they work in a demanding profession which requires managing personal emotional resources. For example, therapists are known to be at high risk of secondary traumatic stress as a result of hearing client trauma histories (Stamm, 1995). Indeed, multiple studies have found that therapists experience high levels of emotional exhaustion (see McCormack et al., 2018, and Lee et al., 2019 for reviews). This is a concerning issue; empathy and connection with clients are vital to support clients with their wellbeing, but high emotional exhaustion puts therapists at risk of depersonalisation. If therapists burn out and disengage emotionally from clients, this will impact the therapy clients receive, as evidenced by emotional exhaustion in therapists being found to reduce perceived standards of care (Garcia et al., 2016). It is therefore essential for both therapists and their clients that risk of burnout is minimised in therapists.

Research into organisational factors which may contribute to or protect against burnout is vital for maintaining a healthy workforce of psychological therapists who can properly support their clients. Much research has been conducted to identify links between propensity for burnout and various aspects of an individual's personality and sociodemographic characteristics. However, the phenomenon of burnout is, by definition, driven by the demands placed on an individual by their occupation (Maslach & Leiter, 2016). Whilst it is important to understand who may be more vulnerable to burnout, ultimately the demands, culture, and resources of an organisation are potentially more modifiable than an individual's characteristics. While interventions which improve individual coping and resilience have been explored (Eriksson et al., 2018; Prudenzi et al., 2022), individual characteristics which have been implicated in risk of burnout such as age, years of experience, and gender are not malleable. It is also essential to maintain caution not to attribute burnout as an issue with the individual just because the impact is experienced by the

individual. As burnout is a consequence of factors within the workplace and employers are legally obliged to maintain a healthy and safe working environment for employees (UK Government, 1999), managing burnout is an ethical issue. Furthermore, the director of workforce strategy for Nuffield Trust described organisations mitigating burnout in healthcare staff as a "moral and ethical imperative" (Imison, 2018).

Previous reviews have been conducted to investigate various factors, including organisational ones, associated with burnout in psychological therapists. O'Connor et al. (2018) conducted a review of the prevalence and determinants of burnout in mental health professionals (MHPs) generally. The authors found high levels of burnout in MHPs, with a prevalence of 40% of MHPs experiencing emotional exhaustion, 22% experiencing depersonalisation, and 19% experiencing reduced personal accomplishment. Of the organisational factors examined in this review, a high caseload, difficult team dynamics or functioning, and lack of control within one's job were found to be predictive of burnout in MHPs. Clarity around one's role, a sense of professional autonomy and fair treatment, and regular supervision were found to be protective against burnout. Furthermore, where findings were broken down by professional group, there was evidence that psychologists present with lower levels of depersonalisation than other MHPs.

Later reviews have looked at psychologists and psychological therapists as a distinct group. McCormack et al. (2018) conducted a review of prevalence and causes of burnout in psychologists specifically. Again, over a third of the studies (34%) endorsed emotional exhaustion as the component of burnout most commonly observed in psychologists, and found evidence that psychologists may be more susceptible to emotional exhaustion than other MHPs. Although the authors looked at both individual and work-related factors, and noted a lack of studies which discussed job demands and work settings, they found workload and perceived time pressure in work significantly contributed to burnout. They also found

that type of work was important; administrative work, and work that psychologists did not feel appropriately skilled in, were associated with higher levels of burnout. Administrative work was also associated with decreased personal accomplishment, as was a larger number of clients. The authors noted that evidence whether private or public sector work is more protective against burnout was mixed, but that control over clients worked with, hours worked, and variability of cases were all protective factors. As private sector work typically allows more choice and control over workload, this may be why private sector work is sometimes associated with lower levels of burnout (Spännargård et al, 2020). The authors also found that readily available co-worker support was negatively associated with burnout. While these results provide valuable insights into work-related factors which may contribute to or protect against burnout for psychologists, this study does not include a variety of psychological therapists. It is worth noting that psychologists may have a variety of roles within a team, including research-based tasks, consultation, and leadership. They are also likely to hold more senior positions than other therapists, such as psychological wellbeing practitioners (PWPs). This role flexibility and seniority may mean psychologists have a different relationship to burnout to other therapists; for example, they may have more control and autonomy over their work, factors that have been found to be protective. However, they also are likely to have more responsibility within teams and work with more complex clients. Therefore, it is important for research to consider psychological therapists more broadly and to examine differences between professions that fall under this broad grouping.

A meta-analysis of correlational studies published from 2006 to 2018 by Lee at al. (2019) looked at a variety of work-related factors (work hours, work demand, role overload, role conflict, role ambiguity, and negative clientele) and their relationship to burnout in psychological therapists. Contrasting with previous reviews, the authors found that rudeness or aggression from clients (‘negative clientele’) was most associated with burnout. They

found that work-related factors were most associated with emotional exhaustion, but found smaller associations with depersonalisation and personal accomplishment. Role conflict, overload, and ambiguity were found to be more important for burnout than hours worked, caseload, or income. The authors inferred from this that subjective appraisals of workload and boundaries of one's role are more important than objective demands or monetary reward. However, the authors did not define how they operationalised the work-related factors they considered and so it is difficult to fully understand the nuance of what elements of the work of therapists contributes to burnout. Furthermore, the authors did not include work-related factors which may be protective against burnout, for example, team functioning, organisational support, supervision or reflective spaces.

Most recently, van Hoy and Rzeszutek (2022) conducted a review of quantitative studies published between 1986 and 2021, investigating both burnout and wellbeing in psychological therapists. The results of this review indicate that, of the work-related factors included, high workload and working in the public sector are associated with burnout whereas supervision is protective, generally consistent with previous research. However, the authors do not elaborate on how they define high workload, or what about supervision is protective, for example, whether it is amount or quality of supervision, or merely the fact of receiving supervision. Additionally, who was included as a psychological therapist was broad, with the authors acknowledging that they included mental health workers, psychiatrists, and coaches in their review. These professions have different training routes, regulations, and roles and the results may not be applicable to psychological therapists as a specific group.

While the results of the aforementioned reviews are valuable and illuminating, it is worth noting they still leave gaps in our understanding. Primarily, even the most recent review (van Hoy & Rzeszutek, 2022) only captured articles published up until 2021, with

nearly half (45%) of included studies more than a decade old. The former three reviews included literature that is less recent than this again. Therefore, much of the literature which has studied the impact of sudden and vast changes to organisations following the COVID-19 pandemic and resulting lockdowns will not be captured by these reviews. The pandemic led to rapid changes in organisational structures, available resources, and workplace demands for all healthcare professionals, including psychological therapists. Notably, many organisations underwent a sudden shift to remote or hybrid working, which had not been common for therapists before. It is to be expected that this shift in organisational demands, ways of working, and resources has had an impact on staff burnout, including in psychological therapists. Furthermore, with the exception of McCormack et al. (2018), who included two qualitative papers, all of the aforementioned reviews only considered quantitative studies. A recent review by Sutton et al. (2022) investigated the impact of organisational factors on vicarious trauma in MHPs). They identified six key organisational factors to play a role in burnout: caseload, trauma training, peer support, supervision, organisational support, and organisational culture. The authors included both quantitative and qualitative studies in their review, and noted that qualitative studies added nuance and further understanding to their results that would have been lost by only including quantitative research. For example, while quantitative studies found no correlation between frequency of supervision and vicarious trauma, and mixed results with regards to perceived quality of supervision, qualitative studies strongly endorsed the importance of supervision. They also concluded that what is perceived as effective supervision differs between individuals and therefore may not be picked up by quantitative studies which aggregate differences amongst groups. This shows the importance of including both quantitative and qualitative literature in reviews which seek to understand the impact of organisational factors.

My aim for this systematic review was therefore to understand organisational factors which are associated with burnout in psychological therapists. I included literature that includes experiences of the pandemic up until 2023, to reflect the experience of the modern workforce. I aimed to understand both factors which contribute to burnout, and those that may protect against it. Due to the rapid changes following the COVID-19 pandemic, in this review I sought to understand factors which are relevant to the modern workforce and therefore only reviewed literature published in the last decade. I included both quantitative and qualitative literature to provide both breadth and depth of understanding of this topic.

Methods

Search Strategy

I followed the guidelines for conducting a systematic review as set out by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) for this review (Page et al., 2021), and followed procedural guidelines as in Higgins et al. (2019). The review was prospectively registered in the International Prospective Register of Systematic Reviews (PROSPERO) – CRD42023392316. Final searches took place in April 2023 on the following databases: PsycINFO, Medline, EMCARE, and CINAHL. See Appendix 1 for an example of the search strategy. Search terms were organised using the 'Population, Outcome, Exposure' format as in Sutton et al. (2022). Population keywords pertained to psychological therapists. The keywords related to outcome were around psychological burnout. The exposure component consisted of keywords around organisational factors. Search terms were piloted and refined to maximise the ability to capture relevant articles. See Table 1 for search terms, which were used in conjunction with Boolean operators and adjusted for each database.

Table 1

Search terms used

Population	Outcome	Exposure
psychologist*	burnout	Work*
psychotherapist*	burn* out	organi?ation*
therapist*	occupational stress	caseload
mental health practitioner*	emotional exhaustion	supervis*
mental health professional*		administrative support
psychological wellbeing practitioner*		peer support
high-intensity therap*		colleague support
		training
		debrief*
		service*
		employ*
		reflective practice
		mental health AJD4 prof*
		mental health AJD4 practition*

Inclusion and Exclusion Criteria

Type of paper

This review included only peer-reviewed, empirical studies published between 2013 and 2023 in English language, from any country. The rationale to include the last decade only was to capture research relevant to the modern workforce. Consideration was given to changes such as the increasing digitalisation of the workplace, and the political ramifications of the 2008 financial crash. Due to differences between countries, and the lag between the crash and implementation of policies which impact healthcare, it is difficult to ascertain an exact date. Therefore, the last decade was used as an approximate. Studies included could be both quantitative and qualitative in methodology, and systematic reviews, meta-analyses, dissertations and letters were excluded. To meet inclusion criteria, studies were required to investigate the relationship between organisational factors and burnout in psychological therapists. Organisational factors were defined as any factor pertinent to the organisation. The

six factors used in Sutton et al.'s (2022) review were used as guidance, as were areas of working life identified as related to burnout by Maslach & Leiter (2016); workload, control, reward, community, fairness, and values. Furthermore, studies which examined remote or hybrid working were included to reflect organisational changes following the pandemic.

Studies were excluded if they only looked at person-centered factors (such as demographic factors, individual histories or mental health, or personality constructs). With regards to in-work training, studies were included if they investigated training related to improving one's skills or knowledge relevant to their role, but were excluded if they related to improving broader individual wellbeing (such as self-compassion and mindfulness). Studies were also excluded if they specified the impact of client-centred factors (such as diagnosis). Factors related to client presentations were only included if they were related to the organisation itself; for example, number of trauma-centred cases on caseloads pertains to job demands and so would be included. Studies which recruited from specific types of service (e.g. forensic services) were included if they focussed on the organisational setup or environment of the service rather than client-centred factors.

Participants

Psychological therapists were defined as those who deliver psychological therapy as a major part of their role, and a primary provision of their training was in psychological therapy. This included but was not limited to clinical and school psychologists, CBT therapists, and PWPs. Only qualified therapists were included in this review. Membership with a professional body was not stipulated as an inclusion criterion due to the cross-cultural nature of the research. This decision was made to avoid potentially excluding countries who did not require professional body registration, and due to my lack of knowledge of which professional bodies are in all countries. Studies were excluded if they studied mental health professionals as a whole (which may include therapists), unless professional groups were

analysed separately so that the impact of organisational factors on therapists specifically could be examined.

Methodology

For quantitative studies, only those that included a validated psychometric measure of burnout (such as the MBI) were included. For qualitative studies, studies were included if they included a definition of burnout which was in line with burnout literature and clearly analysed and made comment about the relationship between organisational factors and burnout.

Quality Assessment

The Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018) was used to assess the quality of the included studies. This tool was selected as it is appropriate for reviews which include quantitative, qualitative and mixed methods studies. It allows for assessment of risk of bias in five study designs: qualitative, quantitative randomised controlled trials, quantitative non-randomised, quantitative descriptive, and mixed methods. This tool consists of two screening questions to ascertain whether quality appraisal is feasible, and then five questions for each study design. Responses as to whether conditions have been met are 'Yes', 'No', and 'Can't tell'. Although Hong et al. (2018) do not advise a scoring system, to allow for ease of visual comparison across studies a score on a 0-5 scale has been given of how many of the five criteria each study has met in Table 2. This approach has been used in other reviews (e.g. Baker et al., 2020; Froehlich et al., 2020). However, for a breakdown based on the aforementioned responses, see Appendix 2. The predominant issues identified across studies were issues of bias in the sample; all studies recruited via volunteer sample, and therefore may be liable to nonresponse bias. Many studies only recruited from one geographical area, although most of these then generalised their results to national

populations of therapists. Furthermore, no quantitative study met the criteria of low risk of non-response bias.

Data Analysis

A narrative synthesis was conducted following guidelines by Popay et al. (2006). These guidelines were initially developed for systematic reviews of healthcare interventions, and include four elements: developing a theoretical understanding of how the intervention of interest works; developing a primary synthesis of data in included articles; exploring relationships in this data; and assessing the robustness of this synthesis.

In line with these guidelines, I familiarised myself with relevant data pertaining to organisational factors associated with burnout, including key gaps in extant literature. I then extrapolated data from included studies which pertained to organisational factors, and synthesised these into six domains based on type of organisational factor they investigated. Following this, I identified any relationships and discrepancies in the findings. Finally, I considered factors which may have led to differences in these findings.

Results

The search strategy identified 2,119 potentially relevant papers. After deduplication, 1,396 papers remained for screening. 1,328 papers were screened out at title and abstract screening, leaving 67 papers for full-text screening. 10% of papers for title and abstract screening were then screened by a research assistant; inter-rater reliability was 89%. Full-text screening identified 15 relevant articles. See Figure 1 for a flow diagram of the screening process. The final body of papers consisted mostly of quantitative, cross-sectional, questionnaire studies with the exception of two papers which were qualitative and utilised semi-structured interviews (Chang, 2014; Sim et al, 2016), and one which was mixed methods (Roncalli & Byrne, 2016). The review included a total of 3,531 psychological

therapists across all studies. Eight of the studies recruited psychologists specifically, one study recruited music therapists only, and the remaining studies included a mix of professional groups trained in and delivering psychological therapy. Sample sizes varied widely from six to 828 participants. All included studies were made up of mostly female participants, with percentages ranging from 57 – 90%. Included studies came from eight countries; five were from the United Kingdom, three from the United States, two from Sweden, and the remaining five were from Australia, Canada, France, Ireland and Portugal. Although five studies were published after the World Health Organisation declared COVID-19 a pandemic on 11th March 2020, only two explicitly state that data was collected after the start of the pandemic (Kotera et al., 2021; Serrão et al., 2022). Therefore, this may reflect a lag between recruitment and the research and peer-review process for other studies.

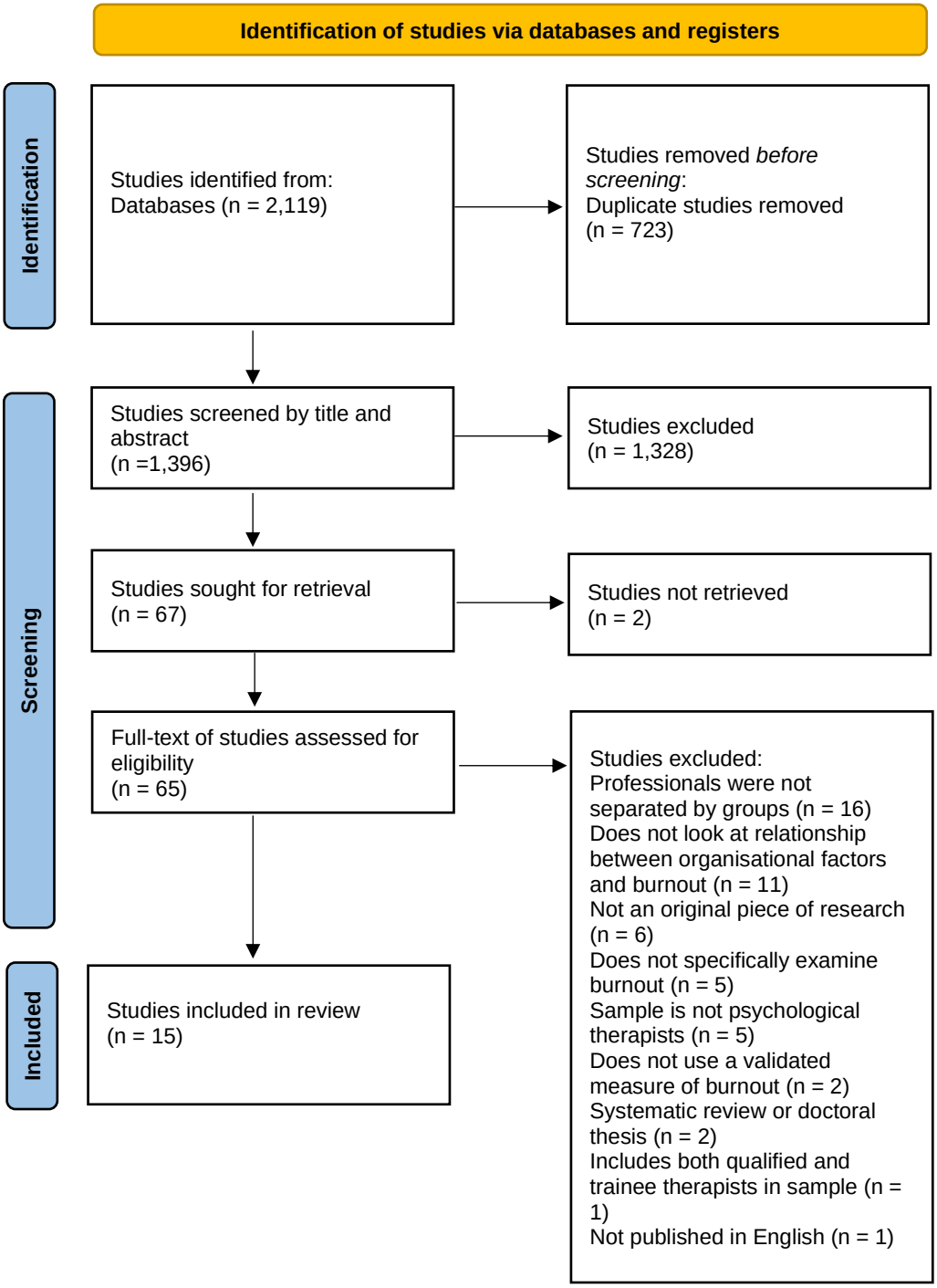

Figure 1

PRISMA flow diagram of study selection

Table 2

Summary of included studies

Author and date	Country	Study participants		Measure of burnout	Type of organisational factor	Key findings	Quality assessment (maximum score 5)
		N, Gender (% female), age (years)	Occupation				
Allwood et al. (2022)	Sweden	828, 78%, M = 43 SD = 11	Psychologists	SMBQ	Job demands – Quantitative Demands, Emotional Demands, Work Pace and Role Conflict subscales of COPSOQ	Job demands predicted exhaustion and disengagement. Models indicated that Quantitative Demands were positively associated with exhaustion, Role Conflict was positively associated with disengagement, and Emotional Demands were negatively associated with disengagement.	4
Berjot et al. (2017)	France	664, 90%, M = 35.44 SD = 9.83	Psychologists	MBI-HSS	Work setting Type of contract Working hours	Working in a private hospital or company associated with high risk of burnout. Independent practice associated with lower risk of burnout.	3

						Working in a public hospital, non-profit organisation or government organisation associated with low personal accomplishment. Working in a private hospital or government hospital associated with risk of emotional exhaustion. Type of contract associated with facets of burnout, with independent status being associated with low risk of burnout and several contracts increasing risk of emotional exhaustion. Working time was not associated with risk of burnout.	
Boccio et al. (2016)	United States	291, 80%, M = 44.73, SD = 12.72	School psychologists	MBI-HSS	Organisational culture - pressure from school administrators to practice unethically	Experiencing pressure from administrators to practice unethically is associated with increased EE and DP and lower PA.	3
Chang (2014)	Canada	6, 83%, Not stated	Music therapists	n/a	Workplace demands – caseload Reward	Excessive caseload for amount of time working in a given facility leaving less time for	5

					Colleague relationships	documentation and reflection endorsed as contributing to burnout. Lack of consistent pay cheque, pension, or paid time off contributes to burnout. A lack of cohesion with teams due to freelance work, feeling like an outsider to the team, or feeling like they are not respected as a professional were endorsed as contributing to burnout.	
Di Benedetto & Swadling (2014)	Australia	167, 87%, M = 42.47 SD = 11.64	Psychologists	CBI	Work setting Colleague relationships Supervision Control over workload	Work setting was not related to burnout. Discussing work frustrations with colleagues significantly associated with work-related burnout. Attending peer support groups was not associated with burnout. Receiving regular supervision was not associated with burnout. Control over work responsibilities, varying work responsibilities, and taking breaks between sessions were not associated with burnout.	3

Johnson et al. (2020)	United Kingdom	298, 79%, M = 41.85 SD = 9.54	Clinical psychologist (n = 172); CBT therapist (n = 63); counselling psychologist (n = 16); nurse practitioner (n = 13); psychodynamic psychotherapist (n = 6); forensic psychologist (n = 5); psychiatrist (n = 3); social worker (n = 1); other (n = 19)	OLBI	Supervision – quality (S-SRQ; Cliffe et al., 2016), frequency Workload – hours worked, number of service users seen per week, number of direct clinical hours per week	After controlling for demographic and workload demands, quality of supervision associated with lower disengagement, but no relationship with supervision frequency. Neither were related to exhaustion. No workload factors included in the model significantly contributed to variance in either disengagement or exhaustion.	3
Kotera et al. (2021)	United Kingdom	106, 83%, M = 47.42 SD = 14	Psychotherapists	MBI (2-item version; West et al., 2012)	Workload demands – weekly working hours Telepressure – pressure to reply to digital communications	Weekly working hours were a significant predictor of both emotional exhaustion and disengagement. Telepressure was a significant predictor of emotional exhaustion.	2

Roncalli & Byrne (2016)	Ireland	77, 77%, M = 37.8 SD = 7.8	Psychologists	MBI	Managerial relationships – item 5, 6 and 19 of MSQ Colleague relationships – item 18 of MSQ Workload demands – weekly working hours	No significant relationship between weekly working hours and any dimension of burnout. Good quality managerial relationships associated with decrease in depersonalisation. No associations found between level of perceived teamworking and burnout. Satisfaction with colleague relationships associated with decreased depersonalisation and emotional exhaustion.	4
Schilling et al. (2023)	United States	100, 84%, M = 42.7 SD = 12.6	School psychologists	MBI-HSS	Caseload – psychologist-to-student ratio Reward – salary Job demands - number of annual evaluations completed	Number of annual evaluations was a significant predictor of emotional exhaustion. Salary and psychologist-to-student ration did not significantly predict burnout. Correlation between salary and personal accomplishment.	3
Serrão et al. (2022)	Portugal	83, 84%, M = 38.2 SD = 9.5	Psychologists	CBI	Remote working (working in office, teleworking, or not working)	Teleworking associated with higher levels of personal burnout, and client-related burnout.	3

Sim et al. (2016)	United States	14, 57%, M = 38.2 SD = 9.5	Psychologists	n/a	Factors that contributed to experiences of thriving or burnout	Contributors to burnout were feeling challenged by work responsibilities, and challenging professional relationships (colleagues and superiors). Support from colleagues was protective against burnout. These results were seen in both early- and later-career psychologists.	4
Sodeke-Gregson et al. (2013)	United Kingdom	253, 72%, 30 - 49	Therapists registered with a professional psychological body	ProQOL	Work setting Caseload - number of sessions, number of clients, number of trauma-focused clients Supervision - hours of individual, group, peer, and consultant supervision per month Perceptions of organisational support – management, administrative, peer, supervision	Perceived management support was a significant predictor of burnout. Risk of burnout decreased as perceived management support increased. Perceived management support, perceived support by peers, and perceived supervisory support negatively associated with burnout. No association between burnout and work setting, caseload, or amount of supervision.	3

Spännargård et al. (2022)	Sweden	327, 80%, M = 47.4 SD = 10.6	Psychologist (59%); Social worker (21%); Nurse (7%); Medical doctor (1%); Other (13%) All currently delivering psychological intervention	CBI	Work setting Caseload – percentage of working time Supervision – participation, format, frequency	Percentage of working time spent in client sessions, having supervision, and frequency not predictors of burnout. Working in private practice was protective against burnout.	2
Steel et al. (2015)	United Kingdom	116, 79%, M = 36.9 SD = 10.4	PWP (42.6%); HI (41.5%); clinical psychologist (6.4%); other (9.6%)	MBI	Psychological Demands, Social Support and Decision Latitude subscales of JCQ	All subscales significantly predicted EE. Psychological Demands significantly predicted DP. Decision Latitude significantly predicted PA.	2
Westwood et al. (2017)	United Kingdom	201, 82%, PWP: M = 32 SD = 9.3 HI: M = 40 SD = 9	PWP (52%); HI (48%)	OLBI	Job demands – hours spend providing supervision/case management, caseload, patient-facing hours per week, hours of overtime per week	Both: Hours of patient contact associated with EE and DP. Hours of overtime associated with EE. Pressure from organisational structure and processes, and relationships with other	3

Environment – access to own desk Supervision – hours received per week Organisational culture – awareness of IAPT targets, organisational structure and processes (subscale of MHPSS) Colleague relationships – relationships and conflicts with other professionals (subscale of MHPSS)	professionals linked to EE and DP. PWPs: Telephone patient hours associated with EE and DP. Hours inputting data associated with EE. Hours of supervision received reduced DP. HIs: Caseload size associated with DP. Face-to-face patient hours associated with EE and DP. Telephone contact and group work hours associated with DP. Awareness of targets reduced both EE and DP.

Abbreviations: EE – emotional exhaustion, DP – depersonalisation, HI – high-intensity therapist, CBI – Copenhagen Burnout Inventory, COPSOQ - Copenhagen Psychosocial Questionnaire (Berthelsen et al., 2018), JCQ (Karasek, 1985), MHPSS - Mental Health Professionals Stress Scale (Cushway et al., 1996), MSQ – Minnesota Satisfaction Questionnaire (Weiss et al., 1967), OLBI – Oldenberg Burnout Inventory,

PA – personal accomplishment, ProQOL – Professional Quality of Life Scale (Stamm, 2010), PWP – psychological wellbeing practitioner, SMBQ – Shirom-Melamed Burnout Questionnaire (Lundgren-Nilsson et al., 2012), S-SRQ – Short Supervisory Relationship Questionnaire (Cliffe et al., 2016)

From my analysis, I identified six domains of organisational factors which contribute to or are protective of burnout. Findings from included studies are synthesised below.

Job Demands

The most extensively explored organisational factor in relation to burnout was job demands, with 12 studies investigating various workplace demands on therapists (Allwood et al., 2022; Berjot et al., 2017; Chang, 2014; Johnson et al., 2020; Kotera et al., 2021; Roncalli & Byrne, 2016; Schilling et al., 2023; Sim et al., 2016; Sodeke-Gregson et al., 2013; Spännargård et al., 2022; Steel et al, 2015; Westwood et al., 2017).

In quantitative studies, job demands were measured in a variety of ways, including working hours, caseload variables, proportion of working time spent seeing clients, or more specific demands. Working hours were measured in a variety of ways; as working full or part time (Johnson et al., 2020), including whether full time hours were across multiple employers (Berjot et al., 2017) or total numbers of hours worked (Kotera et al, 2021; Roncalli & Byrne, 2016). Only Kotera et al. (2021) found working hours predicted both emotional exhaustion and disengagement, with the other studies finding no link between working hours and burnout. Additionally, Westwood et al. (2017) measured hours of overtime in addition to normal working hours in therapists working in UK IAPT services, and did find this predicted emotional exhaustion.

Other studies operationalised job demands as caseload variables. Johnson et al. (2020) measured average clients and average direct clinical hours per week and found neither related

to burnout in UK psychological therapists. Sodeke-Gregson et al. (2013) found no relationship between burnout and number of sessions, number of clients, and number of trauma-focused clients on caseload in specialist trauma-focussed therapists in the UK. Spännargård et al. (2022) also found no relationship between higher caseloads (as a proportion of total working hours) and burnout in Swedish psychotherapists. Westwood et al. (2017) investigated caseload size and hours spent seeing clients face-to-face or via telephone in IAPT therapists in the UK. The authors found hours of patient contact predicted emotional exhaustion and depersonalisation in both high-intensity therapists (HIs) and PWPs. For HIs, caseload size, telephone-contact hours, and group work predicted depersonalisation, and face-to-face contact hours predicted both emotional exhaustion and depersonalisation. For PWPs, hours inputting data predicted emotional exhaustion and telephone-contact hours predicted emotional exhaustion and depersonalisation.

Additional specific job demands measured included work pace, number of annual evaluations, psychologist-to-student ratio. Work pace was not related to burnout in the one study which looked at this (Allwood et al., 2022). Number of annual evaluations completed was associated with burnout, but psychologist-to-student ratio was not in US psychologists (Schilling et al., 2023). Westwood et al. (2017) also investigated hours spent providing supervision and case management, which was not associated with burnout.

Some studies used perceived experience of demands, but did not use specific examples such as working hours or caseload variables. Allwood et al. (2022) found overall job demands were a significant predictor of exhaustion. When they examined standardised coefficients for COPSOQ subscales, they found Quantitative Demands were positively associated with exhaustion, Emotional Demands were negatively associated with disengagement, and Role Conflict was positively associated with disengagement. Role conflict is defined as pressure to achieve simultaneously in two incompatible roles (Jones,

1993). Steel at et. (2015) used the JCQ with IAPT staff, which measured job demands with little control or support. They found Psychological Job Demands were a significant predictor of emotional exhaustion and explained over a third of variance in the model (35.5%). Decision Latitude explained a small but significant amount of variance (2.9%). They also found Psychological Job Demands significantly predicted depersonalisation (accounting for 7% of variance in the model). They also found Decision Latitude was a significant predictor of personal accomplishment, however they included this with another variable around resources in this model and so the impact of Decision Latitude alone cannot be extrapolated. These results indicate that the perception of a large number of demands, pressure to simultaneously achieve in contradicting roles, and having little autonomy over these demands is associated with burnout.

These results are supported by qualitative studies. Participants in Sim et al. (2016) spoke to the perception of being overwhelmed with responsibilities, and that certain high-pressure demands such as crises or emergency appointments, were particularly salient for the experience of burnout. Similarly, Chang (2014) found that participants, who were US music therapists, felt burned out by the expectation to see an unrealistic number of clients within their working day, which left no time for reflection or session-related administrative tasks. Results discuss the experience of being 'stretched too thin' (p.73) as a contributor to burnout, and sometimes reducing caseload was necessary to recover.

Colleague Relationships

Six studies investigated the role of colleague relationships and support as a mediator of burnout (Chang, 2014; Di Benedetto & Swadling, 2014; Roncalli & Byrne, 2016; Sim et al., 2016; Sodeke-Gregson et al., 2013; Westwood et al., 2017). Generally, quantitative studies found that positive, supportive colleague relationships were protective against burnout but that challenging colleague relationships could contribute to burnout. This was true both

for managerial support and support from other employees within the team. Managerial support was found to decrease risk of depersonalisation (Roncalli & Byrne, 2016) and risk of burnout overall (Sodeke-Gregson et al., 2013). Satisfaction with colleague relationships was associated with less emotional exhaustion and depersonalisation (Roncalli & Byrne, 2017) and overall burnout risk (Sodeke-Gregson et al., 2013). However, Sodeke-Gregson et al. (2013) found support from administrative staff did not significantly relate to burnout. Di Benedetto & Swadling (2014) found for Australian psychologists that discussing work frustrations with colleagues, usually seen as a source of support, was associated with increased risk of burnout. However, it is likely that increased need to discuss work frustrations was a consequence rather than cause of burnout. To this end, Westwood et al. (2017) found conflict with other professionals was associated with higher levels of burnout. The authors noted the conundrum of lack of clarity as to whether this was a cause of consequence of burnout, and thus excluded this measure from their regression model.

Qualitative research supports these findings and adds further context. Sim et al. (2016) found US psychologists reported positive colleague relationships as being essential for their ability to thrive at work, and that therapists noted they would turn to colleague support to help them to navigate challenges as work to reduce burnout. However, when relationships with colleagues (including management) were challenging, they were described as a contributing factor to burnout. Similarly, Chang (2014) found that difficult team dynamics were a contributor to burnout in their sample. As freelance therapists, participants discussed how feelings of being an outsider or of exclusion from the team and team events contributed to their experience of burnout.

Supervision

Five studies examined the relationship between supervision and burnout (Di Benedetto & Swadling, 2014; Johnson et al., 2020; Sodeke-Gregson et al., 2013; Spännargård

et al., 2022; Westwood et al., 2017). Studies measured supervision in three main ways; format (e.g. individual or group), frequency, and quality. With regards to format, Sodeke-Gregson et al. (2013) compared individual, group, peer, and consultant supervision, whereas Spännargård et al. (2022) compared individual, small group, and large group supervision. Supervision format was not related to burnout in either study.

Supervision frequency was also almost entirely unrelated to burnout. Di Benedetto & Swadling (2014) measured whether therapists received 'regular' supervision, although the authors do not elaborate how 'regular' was defined. Johnson et al. (2020) measured categorical frequency of supervision (weekly, fortnightly, monthly, bimonthly, or other), as did Spännargård et al. (2022; once-to-twice weekly, once-to-twice monthly, monthly, less frequently). Sodeke-Gregson et al. (2013) measured individual, group, peer and consultant supervision in hours. None of these studies found a relationship between frequency of supervision and burnout. The only significant relationship found was in Westwood et al.'s (2017) study, where more hours of supervision was found to decrease disengagement in PWPs, but not in HIs. Hours of supervision was not related to emotional exhaustion in either group. PWPs also receive practical supervision of their clinical cases known as case management, and this was also not found to be related to burnout.

The quality of supervisory relationship was found to be of importance in therapist experience of burnout. Sodeke-Gregson et al. (2013) found a negative correlation between burnout scores and perceived support received from supervision. Similarly, Johnson et al. (2020) found that quality of supervisory relationship was protective against disengagement after controlling for demographic and workload variables. They did not find a relationship between quality of supervisory relationship and emotional exhaustion.

Organisational Culture

Five studies examined the impact of organisational culture on burnout (Allwood et al., 2022; Boccio et al., 2016; Di Benedetto & Swadling, 2014; Kotera et al., 2021; Westwood et al, 2017). Broadly, evidence from these studies indicate that perceptions of pressure from the organisation are detrimental for therapist wellbeing. Boccio et al. (2016) found that pressure from administrators to behave in ways they feel is unethical increased all three facets of burnout on the MBI in school psychologists. Similarly, Westwood et al. (2017) found organisational pressure from IAPT services increased emotional exhaustion and depersonalisation in PWPs and. This study used the OLBI which does not measure personalised accomplishment. It is however noteworthy that Westwood et al. (2017) predicted awareness of IAPT targets, which can be understood as a form of pressure in itself, would increase burnout. However, they found awareness of these targets was actually protective against EE and DP although do not offer an explanation as to why this may be.

Kotera et al. (2021) also investigated telepressure, defined as the urge to monitor and respond to digital correspondence throughout the day. This reflects an increasing culture of urgency and need to be contactable at all times, which has increased following the advent of remote and hybrid working. The authors found telepressure significantly predicted emotional exhaustion.

Finally, autonomy at work has previously been seen as an important protective factor against burnout. However, in Di Benedetto & Swadling's (2014) study it was found psychologists having control over work responsibilities was not related to burnout, nor was having varied responsibilities or taking breaks between sessions.

Employment Issues

The main organisational factor examined here was work setting. Four studies compared prevalence of burnout in therapists in public and private sector work (Berjot et al.,

2017; Di Benedetto & Swadling, 2014; Sodeke-Gregson et al., 2013; Spännargård et al, 2022). The relationship between work setting and burnout is not completely clear; generally, working in a private, independent practice is protective against burnout (Berjot et al., 2017; Spännargård et al, 2022), although Berjot et al. (2017) found working in private hospitals put therapists at high risk of burnout, particularly emotional exhaustion. Working in public hospitals was associated with decreased personal accomplishment. Holding multiple employment contracts also contributed to emotional exhaustion. Two studies found no relationship between work setting and burnout (Di Benedetto & Swadling, 2014; Sodeke-Gregson et al., 2013), however the latter does not specify if they are referring to public versus private work settings or type or service, and the former specifies a unique aspect of their country's way of working:

> *"The integration of private practitioners as the front line of the public mental health system through the Better Access program (Medicare Australia, 2013b) has seemingly increased burnout levels in psychologists in private practice."* (p.712)

Two studies also looked at financial issues in relation to burnout. Schilling et al. (2023) did not find salary was a significant predictor of burnout in school psychologists. Chang (2014) studied music therapists who were freelancers, and did find issues around lack of benefits of employment (i.e. pension and sick days) and pay. However, this is described as limiting ability to take time off for rest or sickness as days not worked equal a reduction in pay.

Other employment-related issues found to contribute to burnout were around whether therapists had access to a desk (Westwood et al., 2017), and whether they worked remotely or in an office (Serrão et al., 2022). Access to one's own desk was not associated with emotional

exhaustion or disengagement. Working remotely was associated with both higher personal and client-related burnout than working in an office or not working in Portuguese psychologists.

Discussion

To the best of my knowledge, this review is the first to investigate the impact of organisational factors on the experience of burnout in psychological therapists as a specific group. Fifteen studies were identified which explored this issue, and this review highlights five key areas for organisations to prioritise in order to protect the wellbeing of their therapists. To summarise the key findings of this review, job demands were found to be a key contributor to risk of burnout. However, research did not identify a quantifiable threshold of working hours, clinical cases, or proportion of trauma cases associated with burnout. Rather, quantitative research which investigated perceptions of job demands indicates it is this subjective experience which is important. This is supported by qualitative research. Supportive collegial and managerial relationships were protective against burnout, however, when there is conflict or interpersonal difficulties in teams, this can actually contribute to burnout. Organisational culture can also be a contributing factor to burnout, with individuals who feel highly pressured by their employer experiencing increased risk of burnout. With regards to other miscellaneous employment issues, the relationship between work setting, financial compensation, and burnout are less clear. Hypotheses around this will be discussed below. Finally, only one study investigated the impact of remote working and found it to be associated with increased risk of burnout. However, these results are not without conflict which warrant further discussion and consideration.

With regards to job demands, working hours were broadly found not to be associated with burnout. The exceptions to this are, firstly, Kotera et al. (2021), who did find working hours predicted emotional exhaustion and disengagement. It is possible, as mentioned above,

that this is due to only using a two-item version of the MBI. Westwood et al. (2017) found hours of overtime predicted emotional exhaustion. It is difficult to generalise these results as this is the only study which explicitly investigated overtime. However, this is something worthy of further research to understand why therapists were working overtime. For example, it may be that they have excessive demands during the workday and need to work overtime to complete these tasks, explaining the association between overtime and emotional exhaustion. Furthermore, Westwood et al. (2017) found that hours of patient contact, including the format of this contact (e.g. in-person, telephone, group) was associated with burnout. It is notable that of the 12 studies which investigated the relationship between working hours and burnout, the three which found a significant association are from the UK. There has been much discussion in the UK in recent years about staffing shortages following Brexit and COVID-19 (NHS Employers, 2022; Ratwatte, 2023) and difficulties retaining staff, including therapists in the National Health Service (NHS) (Palmer et al., 2021). It is possible that these results are a reflection of particular pressures within the healthcare system in the UK. With regards to other job demands, administrative tasks such as inputting data and number of evaluations completed annually were associated with increased risk of burnout (Schilling et al., 2023; Westwood et al., 2017). This is consistent with McCormack et al.'s (2018) review which indicates type of work is an important consideration regarding burnout, with administrative tasks being a particularly salient demand in relation to burnout.

The most consistent finding with regards to job demands was that it is perceptions of job demands which are crucial for the development of burnout. Quantitative measures of perceived job demands which contributed to burnout were psychological demands (Steel at al., 2015), quantitative demands and role conflict (Allwood et al., 2022). Similarly, qualitative research also indicated that perceptions of being over-stretched or experiencing too many demands contributes to burnout. Interestingly, Allwood et al. (2022) found that

emotional demands were actually associated with *decreased* disengagement. The authors hypothesise that this reflects that experiencing emotional demands reflects that one remains emotionally engaged. Overall, these results suggest that exact blanket targets for caseloads or clinical hours in services may not be appropriate. Rather, caseloads should be flexible and based on discussion between therapists and their managers/supervisors. This reflects the realities of human distress; each therapeutic case will be associated with different demands. Certain service users may require more multidisciplinary working, or time dedicated to risk management or administrative work. Therefore, regular check-ins around perceived workload would be desirable.

Research investigating the relationship between burnout and collegial relationships presents a mixed picture. Di Benedetto & Swadling (2014) identified that discussing frustrations with colleagues is associated with increased risk of burnout. Initially, this seems to contradict with previous research that indicates collegial support is protective against burnout in psychologists (McCormack et al., 2018). However, it is possible that this reflects differences in how availability of support is operationalised. As noted by Di Benedetto & Swadling (2014), it is possible that discussing frustrations with colleagues is a consequence of rather than contributor to burnout. Similarly, this conclusion led to Westwood et al. (2017) omitting conflict with colleagues from the regression model after finding increased conflict between colleagues was associated with burnout. Qualitative literature supports these conclusions, with Chang (2014) and Sim et al. (2016) finding that conflict and feelings of exclusion can lead to burnout, as found in O'Connor et al.'s (2018) review, but equally that colleague support was greatly valued by participants to aid them to manage other demands of work. These results indicate that organisations should be cognisant of including all therapists, including those employed on freelance or part-time basis, and make sure the value of their contributions is known. It also indicates that creating formal and informal spaces for

colleagues to seek support from each other would be of benefit. However, further research is needed to understand the complex relationship between colleague relationships and burnout, and how colleagues and help or hinder wellbeing. For example, qualitative research investigating how therapists perceive colleagues impact their wellbeing, what they find beneficial about colleague support, and in what situations they utilise colleagues as sources of support would be useful.

This review also indicated that supervision was protective against burnout, similar to results found by van Hoy and Rzeszutek (2022). However, it was found that the format and frequency of supervision was not important. Rather, quality of the supervisory relationship is important. Johnson et al. (2020) and Westwood et al. (2017) both found this only decreased disengagement however, and did not impact emotional exhaustion. This indicates that perhaps supervision is not protective against the impact of the demands of the job which contribute to emotional exhaustion, but can support therapists to remain emotionally engaged and connected to their work. However, notably there is no qualitative literature found by this review which explores the relationship between burnout and supervision. As seen in Sutton et al.'s (2022) review of vicarious trauma, qualitative literature is important for adding nuance and depth to results about the importance of supervision quality and therapist wellbeing. Therefore, qualitative research is needed to create insight into what it is that therapists find helpful about supervision to prevent disengagement and protect against burnout. It would also be helpful to understand in what situations therapists would seek informal collegial support, and in which situations they seek the more formal support of supervision.

The results of this review around organisational culture indicate that perceived pressure by the organisation contributes to burnout. Within this review, various studies identified different forms of pressure such as pressure to behave unethically (Boccio et al., 2016), telepressure (Kotera et al., 2021), or perceived organisational pressure within IAPT

(Westwood et al., 2017). This indicates that organisations should integrate consultation with therapists about their perceptions of the organisational culture. However, it is notable that for therapists to feel able to speak about organisational issues such as this it is essential that organisations have a culture of psychological safety. Psychologically safe organisations allow for employees to provide honest feedback, and to actively contribute to culture of their team (Edmonson, 1999). Finally, it is important that organisations action this feedback, and demonstrate how they have used it. It is important that gathering feedback is not seen as a hollow gesture, and something that adds an additional demand (possibly contributing to burnout) without resulting in meaningful and beneficial changes which improve employee welfare. Therefore, organisational culture is an important consideration for organisations.

Previous research indicates that a culture which promotes therapist autonomy is a protective factor against burnout (O'Connor et al., 2018), however, this is not supported by results of this review. However, autonomy was only investigated in relation to burnout in one study (Di Benedetto and Swadling, 2014) and therefore the differences in these results may reflect differences in how autonomy is operationalised. Sim et al. (2016) investigated thriving at work in addition to burnout, and did find that a sense of autonomy is important for thriving, however participants did not comment on autonomy in relation to burnout. Furthermore, Di Benedetto and Swadling's (2014) research only included psychologists. As discussed above, psychologists are typically more senior therapists who likely have more autonomy integrated into their role than less senior therapists such as PWPs. Therefore, it would be important to future research to investigate the relationship between autonomy and burnout in therapists in various roles.

Finally, various employment issues were found to be associated with burnout in this study. With regards to work setting, results generally reflect McCormack et al.'s (2018) previous review which found results to be mixed. Various types of private and public sector

work were associated with different facets of burnout. However, the four studies in the present review which investigated this were from different countries (Australia, France, Sweden, and the UK). It is likely that the mixed results are a reflection of the differences in funding, staffing, and working conditions in various countries, and therefore it is difficult to infer a pattern when comparing international studies of therapists. Similarly, this review presented mixed results as to the relationship between burnout and financial reward, which are likely a reflection of differences between participant groups. Reward (financial or other) was identified as an essential organisational factor in relation to burnout by Maslach & Leiter (2016). However, whilst Schilling et al. (2023) found no relationship between salary and burnout in psychologists, the music therapists in Chang's (2014) study reported that issues around financial reward did contribute to burnout. This likely reflects that the psychologists, who were reported with their annual salary, are likely to have a more stable and reliable income and allowance for time off than freelance music therapists. Further research looking at the relationship between salary and burnout across different countries and various types of therapists would be helpful in understanding more about this relationship. Finally, only one eligible study was identified investigating the relationship between remote working and burnout (Serrão et al., 2022). Whilst it identified that remote work is associated with greater personal and client-related burnout, results should be interpreted with caution. The study recruited in the early stages of the pandemic (May – June 2020), when remote working was a very new experience for many therapists. However, research conducted later in the pandemic on therapist perceptions of remote work indicates that therapists found remote working more stressful and isolating early in the pandemic but viewed it more positively later (Morgan et al., 2022). However, this study did not investigate therapist burnout. Therefore, updated research is required to understand more about remote and hybrid working and its impact on burnout in therapists.

Strengths and Limitations

This review benefits from its specific focus on psychological therapists as a unique group. Additionally, by focussing on research from the last decade only, it presents findings relevant to the modern workforce of psychological therapists. It also benefits from including both quantitative and qualitative studies, which gives richer insight into findings. However, this study is not without limitations. For example, given the paucity of literature investigating organisational factors impacting burnout in therapists, it was essential to include studies which measured burnout using a variety of validated questionnaires. However, these scales measure different aspects of burnout which makes comparison between studies difficult. For example, the MBI measures emotional exhaustion, disengagement, and personal accomplishment whereas the OLBI only measures emotional exhaustion and cynicism. The CBI measures none of these facets, but rather considers burnout in various areas of a therapist's functioning (personal, work-related and client-related). Furthermore, much as in Sutton et al.'s (2022) review, the majority of studies included in this review were cross-sectional methodologies. As Sutton et al. (2022) discuss, this does not allow us to understand causal mechanisms of burnout in therapists but rather factors which are associated with it. This does however highlight a need for longitudinal research to better understand the causal relationship between organisational factors and burnout. The results of this review can provide insight into factors which should be measured in future longitudinal research.

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Part 2: Empirical Paper

Camaraderie, cuts, and COVID-19: Factors affecting the wellbeing of NHS psychological therapists

Abstract

Aims: The NHS is currently struggling to retain staff. Psychological therapists have an emotionally demanding job which can impact their wellbeing in a number of ways. Understanding what these factors are and how best to support psychological therapists to thrive at work is essential to maintaining them within the NHS.

Method: Fourteen UK-based NHS psychological therapists were recruited for semi-structured interviews. Data were analysed using thematic analysis.

Results: Fourteen themes were identified, grouped into five organising domains. Participants spoke of how delivering therapy could give them a sense of achieving and meaning, but also the stress associated with holding distress and risk. A variety of factors which can impact their wellbeing were identified, such as internal desires to over-achieve, conflict with colleagues, and the impact of working in an underfunded healthcare system. Participants also spoke of how their wellbeing was impacted by working during the COVID-19 pandemic. They discussed what sources of support they found most useful, and any perceived barriers to accessing them.

Conclusion: This study supports previous research into unique stressors pertaining to the work of psychological therapists, and adds further context around what sources of support they value. Furthermore, it reflects the impact of working conditions in the NHS on their wellbeing. However, more research is needed to understand specific pressures on certain groups, for example, those services with unique pressures, or therapists from marginalised groups.

Introduction

Psychological therapists (hereafter referred to as just ‘therapists’) work in emotive environments and are exposed to significant amounts of emotional distress within the workplace. Despite this, there is a relative paucity of research investigating the impact of their work on their mental health and wellbeing. A number of risks to wellbeing from this work are described in more detail below, but there is also evidence that therapists can experience enhanced wellbeing from supporting others. Further research into this area specifically focusing on UK-based therapists is essential for three reasons: first, to capture the rapid and significant changes to this work brought about by the COVID-19 pandemic; secondly, to respond to the crisis of recruitment and retention in the National Health Service (NHS); and thirdly, to ensure the wellbeing of the workforce.

A report commissioned by the British Psychological Society (BPS) noted 2,115 vacancies for psychological therapists across the UK in 2020 (Palmer et al., 2021). Furthermore, they indicated that while the majority (93%) of qualifying clinical psychologists will join the NHS workforce full-time within a year, after 15 years this will drop to just over half (55%) still working full-time for the NHS. It is therefore essential to understand how to retain the expertise and experience of therapists trained by the NHS. First, I will consider what is already known about therapist wellbeing, before considering how this has been impacted by the pandemic, and then contextualising the social and political context of the NHS to clarify why updated understandings about the wellbeing of therapists within the NHS are needed.

The two sides of therapist wellbeing

The literature discusses three main constructs associated with therapist wellbeing: burnout (Freudenberger, 1974), compassion fatigue (Figley, 1995), and compassion

satisfaction (Stamm, 2002). The former two relate to impaired wellbeing, whilst the latter relates to enhanced wellbeing. Burnout and compassion fatigue are related and sometimes presented as overlapping, but theoretically are distinct concepts.

Burnout refers to the cognitive and physical consequences of chronic stressors which overwhelm an individual's coping resources (Freudenberger, 1974). It was initially described as a phenomenon associated with working in the caring professions, but now burnout is understood to be a consequence of work-related stress in many fields. Burnout is associated with pervasive emotional exhaustion, increased cynicism towards work (which, for those working in caring professions, may involve depersonalising clients), and a diminished sense of personal accomplishment related to work (Maslach & Jackson, 1981).

Compassion fatigue results in similar cognitive and physical consequences to burnout but conversely is understood to be a direct consequence of empathically supporting individuals following trauma (Figley, 1995). It is related to vicarious traumatisation (McCann & Pearlman, 1990) and secondary traumatic stress (Stamm, 1995). An individual who is experiencing compassion fatigue will have a diminished ability to compassionately engage with others as their mind protectively distances them from the distress they have been exposed to (Figley, 2002). For the scope of this study, the umbrella term of compassion fatigue will be used. However, it is noteworthy that generally vicarious traumatisation refers to changes to schema about one's safety within the world whereas secondary traumatic stress pertains more to post-traumatic emotional experiences such as nightmares, intrusive images, or hyperarousal (McCann & Pearlman, 1990; Stamm, 1995). Although these are theoretically distinct constructs, they are all understood as direct consequences of supporting clients who have experienced trauma. The aforementioned constructs are essential to be aware of as they can all have a detrimental impact on both the therapist themself and the clients they are supporting. For therapists, they can lead to impaired mental and physical health, and reduced

satisfaction and engagement with work. Therapists who experience burnout and compassion fatigue may be less able to support their clients and to compassionately and empathically connect with them (Salyers et al., 2015; Delgadillo et al., 2018).

Given that working as a therapist exposes the individual to a significant amount of distress and trauma, it is pertinent to consider what it is about this work that may enhance one's wellbeing. Caring professions are generally considered rewarding roles, and it is important to consider what attracts individuals to and keeps them in such emotionally demanding careers. There is comparatively less research into positive impacts on therapist wellbeing than detrimental impacts. Generally, what is known falls under the umbrella of compassion satisfaction, which refers to the enjoyment and personal satisfaction one gets from working in a caring profession. It is often described as a result of feeling one is doing good for others and making a difference to clients' lives (Larsen & Stamm, 2008). While earlier research investigated individual factors associated with compassion satisfaction, more recent research has explored organisational context, which is more potentially modifiable. This research indicates a supportive organisation is an important factor to improve compassion satisfaction and decrease the risk of burnout (Boscarino et al., 2004; Sodeke-Gregson et al., 2013).

There are a number of risk and protective factors which come up repeatedly in the literature. To highlight this, results from systematic reviews exploring factors associated with compassion fatigue (Lerias & Byrne, 2003; Sutton et al., 2022) and burnout (McCormack et al., 2018; van Hoy & Rzeszutek, 2022) in therapists will be considered. Particularly salient demographic factors for both compassion fatigue and burnout are age and gender. Consistently, younger therapists have been shown to be more susceptible to detrimental psychological consequences of their work. There are a variety of arguments as to why this is – for example, that life experience is protective against compassion fatigue (Lerias & Byrne,

2003), older therapists learn to preserve their emotional energy throughout their career (Ackerley et al., 1988), or that younger therapists are negatively impacted by the realities of their career not living up to their expectations (van Hoy & Rzeszutek, 2022). Similarly, in research female therapists consistently show greater vulnerability to burnout and compassion fatigue. However, it remains unclear why this is; van Hoy & Rzeszutek (2022) postulate that women are more likely to express their emotions than men. However, it is also very possible that women experience different pressures and demands to men as a result of living in a patriarchal society, such as greater emotional and domestic labour, and experiencing less recognition within the workplace. Such factors may reduce their available resources and explain their greater vulnerability. However, more research into the relationship between gender and the emotional impact of therapeutic work is needed.

Notable factors within the workplace associated with compassion fatigue and burnout are related to job demands, occupational culture, support from colleagues, and supervision. The most consistently evidenced risk factor pertains to job demands; across the aforementioned reviews (McCormack et al., 2018; Sutton et al., 2022; van Hoy & Rzeszutek, 2022), higher job demands are consistently found to put therapists at increased risk of burnout and compassion fatigue. However, it is less clear what demands are particularly salient. Various studies have investigated working hours, client-facing hours, time spent working on administrative tasks, and factors related to caseload (e.g. proportion of trauma clients, or types of traumas). While quantitative results are mixed, the take home message is that both type and amount of work are important to consider (McCormack et al., 2018). Qualitative results support the view that therapists' perceptions of their workload are the important factor (Sutton et al., 2022). Finally, supervision and colleague support have been endorsed repeatedly as important protective factors against burnout and compassion fatigue. Results are, however, mixed as to whether frequency, amount of, or quality of supervision is

most important, and colleague relationships have also been found to be a potentially contributing factor to compassion fatigue (Sutton et al., 2022).

The impact of the pandemic on therapist wellbeing

When the World Health Organisation (WHO) declared the COVID-19 pandemic in spring 2020, healthcare organisations were required to respond rapidly to the enormous strain upon them. The UK population experienced multiple restrictions and protective measures to minimise spread of infection, including social distancing and national lockdowns. Drastic operational restructuring occurred across the NHS, with urgent requirements made to convert wards to facilitate COVID-19 patients, the opening of specialist COVID-19 'Nightingale' hospitals, and redeployment of staff. The impact on healthcare staff and increased levels of psychological distress, burnout and moral injury are well documented (Galanis et al., 2021; Rushton et al., 2022; Shreffler et al., 2021). However, less research has explored the impact on mental health professionals (MHPs) and less still on therapists as a specific subgroup.

The role of many therapists changed during the pandemic. Some were redeployed to support frontline healthcare staff. This support was both practical, in that therapists were redeployed to support in patient-facing roles (e.g. on wards), or psychological support, such as delivering support services for frontline staff. Others remained in their existing roles, but were required to put their health at risk by continuing to offer in-person appointments, for example those in hospitals or working with high-risk groups. Other therapists experienced a sudden shift from in-person to remote work. An early systematic review of 55 studies exploring the impact on MHPs both personally and professionally highlighted an increase in workload, blurred boundaries between personal and professional lives, reduced confidence in professional abilities, moderate-high levels of burnout and compassion fatigue, and exhaustion from remote work (Crocker et al., 2023). In a qualitative study of UK mental health professionals at the end of the first wave of the pandemic, participants spoke of the

isolation they experienced working remotely, being exposed to traumatic and distressing material in their own homes, and the disconnection from usual support systems (Billings et al., 2021). This included being unable to engage in social support and hobbies which would usually help to manage wellbeing, due to restrictions. Additionally, therapists were noted to neglect their own wellbeing needs in order to support their clients. Finally, exposure to bereavement and illness, both from working on wards and through supporting staff and hearing about the work they were doing, led to vicarious traumatisation and vicarious moral injury. Furthermore, the authors highlight previous evidence that therapists who experience the same traumatic context as the clients they are supporting (e.g. Hurricane Katrina, Lambert & Lawson, 2013, and 9/11, Culver et al., 2011) are at increased risk of adversely impacted wellbeing from burnout and compassion fatigue.

As restrictions have lifted and the initial crisis point of the pandemic has passed, remote and hybrid working have remained for many therapists. Whilst much has been published about the experience of and efficacy of teletherapy (therapy conducted via telephone or video call) for clients (e.g. James et al., 2022; Thompson-de Benoit & Kramer, 2021), less has been published about the impact these organisational changes have on the therapists providing them. A study of eight therapists working remotely during the second wave of COVID in the UK and during lockdown (Morgan et al., 2022) found similar themes to Billings et al. (2021) around therapists feeling isolated from colleagues and usual sources of peer support, and the blurring of boundaries between personal and professional lives. However, these interviews conducted later in the pandemic reflected a shifting view towards remote work and associated hopes for future improved work-life balance. However, updated research is needed to understand the relationship between remote working as society adjusts to the ‘new normal’ following the pandemic. It is possible that remote working is still seen as a source of isolation and disconnection from interpersonal support at work. However, it may

also be the case that post-lockdown it is seen as an enhancer of wellbeing as therapists have reduced demands (such as commuting and difficulty finding clinic space) and more time engaging in social support and relaxation, which protect against burnout and compassion fatigue.

Social and political context of the NHS in 2023

It is essential to contextualise the socio-political landscape in which this research has been conducted. The UK has been governed by the Conservative Party since May 2010. The party introduced a programme of austerity as a response to the 2008 recession, aiming to improve the economy by means of reduced public spending. This had a dual impact on the NHS: first, directly reducing spending on healthcare, and secondly, increasing social determinants of ill-health (see Reeves et al., 2013 for an overview). Whilst reduced healthcare spending directly impacts the provision of healthcare interventions, nearly half of the NHS budget is spent on workforce salaries (Department of Health and Social Care, 2023) and to manage spending the government instigated pay freezes followed by below-inflation pay increases.

In their sixth year in government, the Conservative Party held a referendum (known as the 'Brexit' referendum) regarding whether to remain in or leave the European Union (EU). A contentious slogan used by politicians in favour of Brexit indicated that it would lead to increased funding of the NHS (see Appendix 3). To the contrary, modelling has indicated that Brexit has detrimentally impacted the UK economy, including healthcare spending (Springford, 2022). Brexit has additionally led to significant reductions in the availability of EU healthcare professionals in the UK workforce - a group on which the NHS had previously relied - and increased outward migration from EU nationals already in the NHS (see Dalingwater, 2019 and Dayan et al., 2020 for overviews).

Staffing levels were a notable issue prior to the COVID-19 pandemic, with concerns raised about an overstretched workforce and increases in work-stress related absences increasing (Wilkinson, 2015; Rimmer, 2018). However, the impact of Brexit on the workforce was compounded by the pandemic, with 135,000 fewer workers migrating into the UK in 2020 than expected (Dayan et al., 2020). In addition to further reducing inward migration of workers, the pandemic compounded other existing pressures on NHS workers such as low morale and burnout as well as exacerbating concerns over inadequate pay (Best, 2021; Germine et al., 2021).

There is acknowledgement that the supply of workers to the NHS does not meet demands, and that the workforce is exhausted and overstretched following the pandemic (NHS Employers, 2022a). The NHS is currently considered to be in a retention crisis (Ratwatte, 2023), as it struggles to maintain those it has trained or invested in due to low wages and unsatisfactory working conditions (Bimpong et al., 2020; Dobson, 2023; Kirby, 2023). Certain professional groups, such as nursing (Dayan et al., 2020), or specialist areas, such as mental health, are particularly affected. For the first quarter of 2023, there were 26,836 mental health vacancies across NHS England, with mental health vacancies being consistently higher than the average vacancy percentage for every region (NHS Vacancy Statistics, 2023). Concerns over salaries which have not risen with inflation, inadequate staffing levels and working conditions have led to strike action by a number of unions representing healthcare staff such as nurses, paramedics, and doctors in the UK following an NHS pay offer made by the government in July 2022 (Department of Health and Social Care, 2022). Strike action began in December 2022, and was ongoing at the time of writing (Garratt, 2023).

Aims of present research

This study sought to understand how psychological therapists working in the NHS perceive the impact of their work on their mental wellbeing, the sources of support they find most valuable, and what factors facilitate or create barriers to accessing that support. This research aims to provide an up-to-date understanding of the factors impacting wellbeing in NHS psychological therapists in the context of recovery from a global pandemic.

Methods

Ethical approval

This study was approved by the University College London Research Ethics Committee (Ref: CEHP/2019/576; see Appendix 4).

Participants

The inclusion criteria for this study were as follows:

1. Qualified psychological therapists (that is, individuals for whom a major part of their training and current role was to deliver evidence-based psychological therapies)
2. Currently working in the NHS
3. Qualified for at least one year prior to participating in the study

Procedure

Sampling

The study was advertised on the social media networks Twitter, LinkedIn, Facebook (including 'groups' for therapists), and Instagram. Participants were recruited via volunteer sampling. However, to obtain a variety of experiences and viewpoints, purposive sampling was also used. For example, attempts were made to recruit Scottish therapists, and when the sample was overwhelmingly male only female therapists were recruited to improve balance. After making contact with the researcher, participants were asked to confirm their occupation

and that they had been qualified for more than one year. They were also sent a participant information sheet to read and consent and sociodemographic forms to complete (see Appendices 5, 6 and 7). After returning completed consent and sociodemographic forms, they were asked if they wished to conduct the interview face-to-face on University College London premises, or sent a booking form for remote interviews slots to be conducted via Microsoft Teams. All participants opted to be interviewed remotely.

Interviews

Upon meeting for the remote interview, information about the study was reiterated. Participants were informed that they would be asked about their mental health and wellbeing in relation to their work across their whole career as a qualified therapist. Participants were advised that they could decline to answer questions or stop the interview at any point. Interviews were conducted between August 2022 and February 2023. All interviews were conducted by the lead researcher directly with each participant alone, with the exception of two interviews which were observed by a research assistant. The interviews were semi-structured and guided by an interview schedule (see Appendix 8).

The interview schedule began with some broad questions about the participant's role to gain an understanding of their context and build rapport. The aims of the interview questions were to gain a rich understanding of ways in which participants' work as a therapist may both enhance and negatively impact their wellbeing. Questions subsequently explored what sources of support interviewees found particularly beneficial in managing their wellbeing, and any barriers they encountered in accessing these. Questions were asked about how their role changed during the COVID-19 pandemic, the impact of this on their wellbeing, and the sources of support which were in place around this. Additionally, participants were asked about any changes they thought would be beneficial to supporting their wellbeing.

Data analysis

All interviews were initially transcribed using automatic transcription services Scrintal and Microsoft Teams. Interviews were then thoroughly checked for accuracy and edited as needed by the lead researcher, or by a research assistant and later double-checked by the lead researcher. Interviews were transcribed throughout the period of data collection. A reflective journal was used throughout this process and initial reflections on the data were noted in the journal during transcription.

The transcripts were analysed using reflexive thematic analysis (Braun & Clarke, 2006; 2022). Thematic analysis is a qualitative methodology which seeks to identify common narratives or 'themes' in data. Reflexive thematic analysis is an epistemologically flexible methodology, which is grounded in the use of personal reflexivity by the researcher and is explicitly distinct from positivist methodologies. This research adopted a critical realist epistemology. Critical realism seeks to understand participants' experiences as they are presented, but allows for interpretation of these using language and social context (Bhaskar, 2010). The process of reflexive thematic analysis as proposed by Braun & Clarke (2006) consists of six phases, which is the guidance I followed for this research. For familiarisation, the lead researcher re-read the transcripts multiple times and made notes of initial reflections in a journal. These were discussed in meetings with supervisors throughout the analysis process. Coding of transcripts was completed using NVivo Pro V12. Coding was an iterative process and I went back and forth between transcripts and codes. After codes were finalised, ideas about themes were generated and discussed amongst the research team until five organising domains were agreed. Codes were then grouped by these and compared against the organising domains to identify whether they fit. Once we decided that codes and domains were congruent, codes were collapsed by grouping them by common topics which were then labelled with the concept which connected them. Once all codes had been collapsed, these

topics were further grouped to generate themes. See Appendices 9, 10 and 11 for evidence of this process. These themes were discussed with research supervisors as part of the process of defining and naming the themes.

Reflexivity

Personal reflexivity is an essential aspect of thematic analysis and qualitative research more broadly. It is accepted that whilst the researchers' experiences and perspectives will inevitably inform their research questions and interpretations of the data (Braun & Clarke, 2006; 2022), reflecting on these and actively attempting to incorporate alternative perspectives is important to provide the reader with information about the lenses through which the researchers have understood the data.

At the time of conducting this research, I was working as a trainee clinical psychologist, with experience volunteering and working in various roles within the NHS since 2010. I began developing this research in early 2021, after a year of working as a pre-qualified therapist during the pandemic. My own experiences of supporting clients while processing my own experience of the pandemic and adjusting to new ways of working attracted me to the topic. 'Insider' status as a qualitative researcher comes with benefits and drawbacks (Hayfield & Huxley, 2015). For example, first-hand experience of working in the NHS during the pandemic and of delivering therapy pre- and mid-pandemic provided insight when developing the research questions. However, this also resulted in the possibility of prioritising certain viewpoints which fit with my own experiences. To minimise this, I sought to recruit a broad sample of therapists from different professional backgrounds and geographical locations to maximise diversity of experiences. Both research supervisors were also qualified clinical psychologists and clinical academics who had previously worked in the NHS. I believe this was a strength as we all had both 'insider' status as therapists, but also

‘outsider’ statuses as individuals still in training or working in academia. We utilised research supervision to discuss data which reflected differential experiences to my own and explicitly reflected on these alongside writing. In addition to this, I kept a reflective diary in an effort to examine how my personal viewpoints may be impacting the research process. For example, I used this to reflect during transcription on where my questions could be developed. Time as a barrier to accessing support was raised in multiple interviews; I had not asked follow up questions as I had my own assumptions about where lack of time came from, and how this impacted ability to seek support. Using my reflexive diary prompted me to ask direct questions about time as a barrier when it was discussed, to ensure my analysis was based on what participants explicitly said about this rather than making assumptions from my own experiences. It also helped me to separate what I found interesting from what directly answered my research questions. An example of this was that multiple participants discussed the impact systemic issues had on service users. I used my reflexive diary to consider if I was interested in such quotes because they answered a question about impacted therapist wellbeing (e.g. feelings of stress or guilt at not being able to offer interventions due to service constraints), or interested as a practicing trainee psychologist (e.g. the emotional impact on service users).

Contextual frame

After two years of pandemic-related restrictions in the UK, all legal measures were lifted in England in 2022. Although individual NHS Trusts may still have had guidance around social distancing and mask usage, by the point interviews began participants were no longer subject to lockdown restrictions. The immediate crisis of the pandemic had passed and most pre-pandemic social and leisure activities had returned by summer 2022. There had also been public discourse around NHS salary and working conditions following the pay review in

July 2022, and strike action by nurses, paramedics and doctors began from December 2022 (Garratt, 2023). Intermittent strike action continued throughout the remaining period of interviews.

Results

Fourteen participants were recruited. See Table 1 for an overview of the sociodemographic characteristics of the sample.

Table 1

Sociodemographic characteristics of the sample.

Characteristic	*n* (%)
Gender	
Male	8 (57)
Female	6 (43)
Age	
18-25	1 (7)
26-35	5 (36)
36-45	4 (29)
46-55	3 (21)
56+	1 (7)
Ethnic Group	
Asian or British Asian	1 (7)
Black African, Black British, or Caribbean	1 (7)
Mixed or multiple ethnicities	1 (7)
White British, White European, or White - other	10 (71)
Other ethnic group	1 (7)

Geographical Region	
England - London	3 (21)
England - Midlands	2 (14)
England – North East	1 (7)
England – North West	3 (21)
England – South East	2 (14)
England – South West	1 (7)
Wales – South Wales	2 (14)
Professional Group	
Integrative Psychotherapist	1 (7)
Clinical Psychologist	7 (50)
Cognitive-behavioural Therapist	3 (21)
Psychological Wellbeing Practitioner	2 (14)
Social Worker	1 (7)
Setting	
CAMHS (Community Setting)	1 (7)
Forensic service	2 (14)
General/acute medical hospital	1 (7)
Secondary care	5 (36)
Primary care (including IAPT)	4 (29)
Primary care (including IAPT) and secondary care	1 (7)

Data analysis identified 14 themes, which were separated into five organising domains (see Figure 1). These will be considered in turn below and illustrated with verbatim quotes from

the interviews. Where parts of quotes have been omitted for brevity, this is indicated by ellipses. All participants have been given pseudonyms. They are noted with a brief context of their current role, or most recent qualified role if they are now in further training.

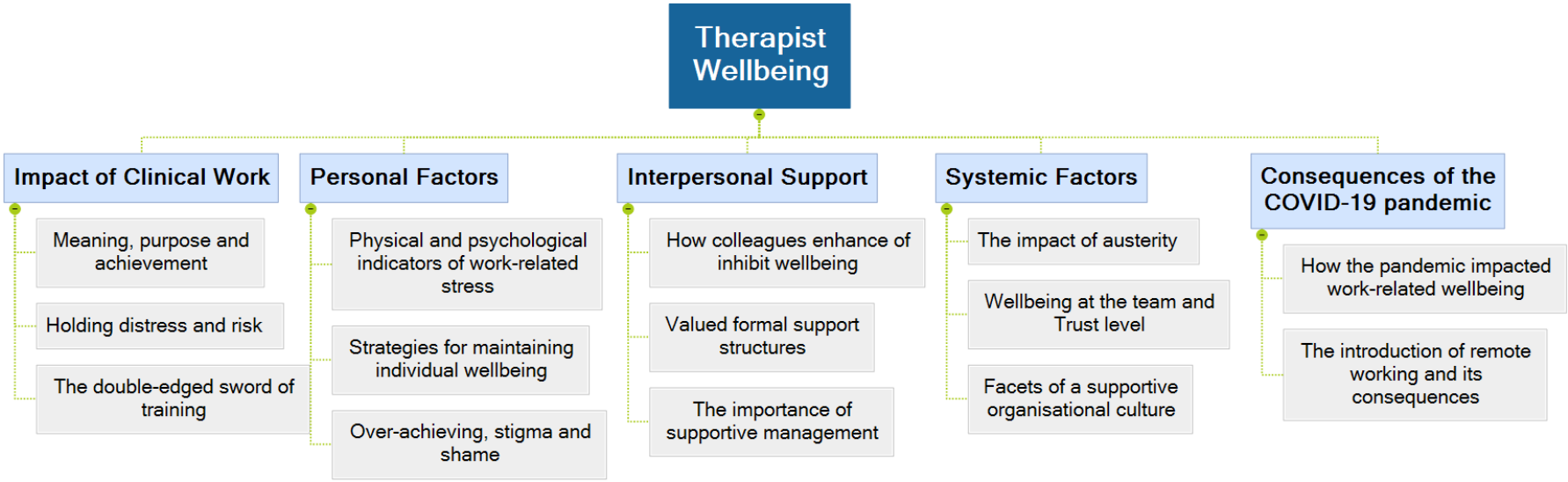

Figure 1

A map of themes and organising domains.

Impact of clinical work

Meaning, purpose and achievement. All therapists spoke positively to some degree about the value of their direct clinical work in providing a variety of benefits, including a sense of compassion satisfaction, doing good for others, and providing achievement, purpose, and mental stimulation.

A variety of responses were given about the rewarding nature of delivering therapy and facilitating meaningful change in clients' lives, and of witnessing improved outcomes. They also spoke about this work as a privilege, and valued being able to "see the effects not just on our service users, but also the effects on families" (James, principal clinical psychologist, secondary care).

> *So just seeing people getting better, it's, yeah, it's worth you know more than anything really. I had a lot of pleasure from that.* (Kofi, PWP, primary care).

> *My wife encourages me to reflect on times where not only it's just the person in the room, that it's gone well for. But the, the knock-on effect on families, and social dynamics, and things like that…It's it is a, a very, very rewarding role. It comes with its pitfalls, and it comes with its stresses, but … I still find it very rewarding role.* (Mark, CBT therapist, primary care)

Multiple participants discussed the "intellectual challenge" (Jennifer, principal clinical psychologist, secondary care) of their clinical work and enjoying the aspects of problem solving involved in making sense of clients' difficulties and developing treatment plans. This mental stimulation was important for wellbeing at work as interviewees felt it gave them a sense of variety and enjoyment in their workday. For some participants,

particularly those who had been qualified for a longer period of time, this sense of enjoyable intellectual challenge was particularly salient when working with complex clients.

> *I love puzzle solving, and problem solving, and getting in there and, and being a little bit detective about figuring out with people, and so that again that just plays to something I like personally, and that innate curiosity.* (Mark, CBT therapist, primary care)

Holding distress and risk. Participants also spoke of the impact that exposure to other people's distress, a sense of responsibility and risk management had on their levels of stress and anxiety. Broadly, participants recognised the "abnormal exposure to suffering" (Katie, newly qualified clinical psychologist, secondary care) experienced as a therapist, and that at times work could leave them feeling "quite stressed, quite overwhelmed and emotional" (Tom, CBT therapist, primary care). Across interviews, therapists spoke of repeated exposure to distressing material such as accounts of traumatic events, bereavements, abuse, and crimes committed against others. There was an awareness that "speaking to people all the time about these horrible things that happened and sort of managing all that worry" (Asha, clinical psychologist, secondary care) was a unique aspect of the role, and interviewees acknowledged that exposure to others' suffering would inevitably provoke negative emotional responses at times.

There were mixed opinions as to the impact of this on therapist wellbeing. Two participants acknowledged transient emotional reactions, such as sadness, however they stated that this felt like a manageable or expected part of their job. Rather, they argued organisational pressures had a more significant impact on wellbeing than emotive client work.

Yes, of course, that's very sad, but it doesn't impact on my mental health at all. I think what impacts on my mental health is the quantity of work that's required, the pressure to try and provide the service I would want us to be providing in the context of the limited resources we have. The amount of plate spinning with different pieces of my work that I have. (Liz, clinical psychologist, acute medical setting)

There was also concern over the lasting impact of chronic exposure to distress over the course of a career. Multiple participants reflected that although exposure to distress usually had a short-term impact – for example, impacting their mood for a day or so – that they believed "there must be a kind of a slow rolling effect, where you desensitize and, having heard so much horrible stuff" and feeling "sure it does take a toll on some level" (James, principal clinical psychologist, secondary care).

Another commonly discussed topic was around the emotional impact associated with risk management. Participants discussed the impact personally and professionally of being a direct recipient of physical or verbal aggression, but also about the psychological impact of managing clients' risk to self or others.

For the first time since I've worked on the unit, I had two days off because of the impact of someone's tongue lashing. And a threat of violence as well…I've always prided myself on being quite resilient, but this time it really did hit me. (Paul, psychotherapist, forensic service)

Managing clients' risk was discussed as something which provoked stress and anxiety. This was especially prevalent in those who were newly qualified. These therapists

discussed a lack of confidence in their competence when adjusting to the "extra burden" (Katie, newly qualified clinical psychologist, secondary care) of the sudden increase in clinical responsibility. This was compounded by a lack of clear support structures, or being referred clients they felt inadequately trained to support.

> *When I first started the role, I felt really, really stressed when any risk came up, um, like anyone could have said anything to me about risk and be like, "no, don't speak to me about it!"* (Lucy, newly qualified PWP, primary care)

The double-edged sword of training. Additional therapeutic training post-qualification was something that was discussed as having both benefits and drawbacks for wellbeing, sometimes simultaneously. When training felt well-implemented and relevant, therapists felt more competent and less anxious about supporting clients. Additional training sometimes came with more supervision hours as further support. However, when training felt irrelevant, it had the impact of becoming an additional burden on time, and left participants feeling deskilled. Katie spoke to her mixed feelings about going through required further training at multiple points in her interview.

> *It just ends up feeling like you're kind of engaging in a bit of a farce, and your clinical work still feels really difficult because you don't have access to the training that is going to really support the work that needs to happen…I've got bloody loads of extra supervision as well, which is like a bit of a pain because you've gotta play tapes, but like, it's actually quite a lot of extra time at a time where I was still like learning and developing.* (Katie, newly qualified clinical psychologist, secondary care)

Personal factors

Physical and psychological indicators of work-related stress. A number of participants spoke about the importance of "checking in with [themself]" (James, principal clinical psychologist, secondary care) and being aware of their personal indicators of impaired wellbeing. They discussed this recognition as foundational to being able to manage work-related difficulties. Generally, therapists were able to identify short-term indicators of stress relatively easily. They spoke of somatic experiences such as tension, churning or tightness in the stomach, sore throats and headaches. However, they acknowledged that frequently it was partners and friends who suggested a link between work stress and somatic experiences. Additionally, a common narrative was difficulty recognising the longer-term impacts of stress. Katie speculated about why this may be:

> *It feels a bit more, a bit more detached from specific situations, I think it feels a bit harder to pin down as 'Oh, this is actually, this is work'.* (Katie, newly qualified clinical psychologist, secondary care)

The three experiences participants most commonly endorsed as a symptom of more chronic stress or burnout were impaired sleep, ruminating about work outside of work hours, and exhaustion. Behaviourally, some participants also noticed they were struggling when they were neglecting their basic needs such as sleep, diet, and rest time. Fatigue and impaired sleep were both a consequence of and a maintaining factor of impaired wellbeing. James reflected on the consequences of work stress:

> *I wake up really early in the morning, and I'll be thinking, and a bit of a stomach churning or worry or whatever that is, because it's on my mind and what that then*

does is spoil my sleep patterns, which has a devastating effect on my mood and everything else. And then I can't concentrate when I'm really tired. (James, principal clinical psychologist, secondary care)

***Strategies for maintaining individual wellbeing*.** Unsurprisingly, participants spoke about using knowledge of therapeutic models to understand and manage their own wellbeing, and the pull to "therapise [themself]" (Tom, CBT therapist, primary care). Participants were easily able to identify the important aspects of self-care they used outside work: social time with friends and family, time with pets, exercise, and getting into nature were frequently endorsed. However, participants also acknowledged practical barriers.

You need to keep that healthy kind of work-life balance. But again, easier said than done when you're stressed and you've got a thousand things to do. (James, principal clinical psychologist, secondary care)

Participants also frequently endorsed their own private therapy as an essential component of managing wellbeing. They discussed both managing personal difficulties and coping styles in therapy, but also explicitly the importance of having a space to be able to speak about work stressors in an unfiltered way. Paul gave an example of personal therapy helping to manage conflicts in a way that did not always feel possible in supervision:

*There are limits with any, any work relationship. And I'm not gonna speak in a particular way about a colleague to him. Whereas I can go to my therapist and go "That f***er, he really p***ed me off!". You know, there's a difference, isn't there?* (Paul, psychotherapist, forensic service)

Finally, many participants endorsed the importance of enforcing rest breaks or firm boundaries around working hours. Some participants spoke of the importance of not giving into the "culture of constantly needing to be doing" (Asha, clinical psychologist, secondary care) especially without being paid for additional time, although this was something many struggled to achieve consistently.

> *The NHS isn't a charity project. (*Katie, newly qualified clinical psychologist, secondary care).

Participants discussed the difficulties of managing this as remote work became more common, such as not having work emails on their phone or having dedicated spaces to work at home. However, managing family and working life often proved challenging. It is also worth noting that this stance of firm boundaries was not unanimous; some participants challenged the belief that they should refrain from thinking about clients at home. Others felt their wellbeing was not negatively impacted by taking work home.

> *Occasionally I end up using my own time to try and catch up on things. And I'm not terribly worried about that. I mean, some people feel like they need to be very, very boundaried around their own time. I'm not that bothered.* (Jennifer, principal clinical psychologist, secondary care)

***Over-achieving, stigma and shame*.** Participants spoke to an awareness of their individual traits which could contribute to impaired wellbeing. A number of participants spoke of their "compulsive volunteering" (Jennifer, principal clinical psychologist, secondary

care) and awareness of their likelihood to “over-commit” (Liz, clinical psychologist, acute medical setting) to various projects in work. Jacob reflected on the pressures of training and high competition for therapist roles as a possible source of this:

> *I was filling essays in with baby in papoose, bouncing up and down…there was a lot of blurring of boundaries and then getting it, actually into the role when competition was quite high for that. It was almost like demonstrating of self, and going above and beyond and maybe doing stuff that wasn't even noticed.* (Jacob, CBT therapist, CAMHS)

Participants spoke about a variety of contributing factors to their reluctance to access formal wellbeing support, such as lack of awareness of what is available or wanting support from existing relationships. One participant acknowledged a lack of self-compassion as the main barrier they experienced.

> *I find it much easier extending compassion to other people than I do to myself. And if somebody was sat in front of me saying what I was saying, I might think of the well-being service and offer, offer them that. But when it's for me, I think that's really what it is…it's a lack of kindness to myself.* (David, psychotherapist, primary care)

Participants also spoke of the impact of internalised stigma at being a therapist who needs support with their own wellbeing. One participant surmised the beliefs around this:

> *Something I used to think, something a lot of people think, this idea that as a therapist, psychologist, whatever, I need to be strong enough. How can I help people if I'm not mentally strong?* (Tom, CBT therapist, primary care)

Interpersonal support

How colleagues enhance or inhibit wellbeing. Overwhelmingly, participants spoke about colleague relationships as the most accessible and valued source of wellbeing support. Colleagues were valued for sharing knowledge and ideas and for offering informal debriefs or a space to vent. Many spoke of a "work family" (Kofi, PWP, primary care) and that "people's what makes [the stressors of work] OK" (Jennifer, principal clinical psychologist, secondary care). Humour and conversation between colleagues were described as protective against burnout and essential for their enjoyment of a job:

> *If I didn't have people that I connected with and could have a laugh with, I don't know how I would carry on doing this job. Probably not. I probably would leave.* (Asha, clinical psychologist, secondary care)

When asked about what they desired to support wellbeing, multiple participants spoke of protected time for bonding with colleagues, both on a weekly basis and as team days. With the move to remote work, participants spoke of maintaining connections through informal conversations on Microsoft Teams. However, there were caveats to the availability of collegial support. Participants often spoke about the impact of their work on their wellbeing in hopes if normalising this for colleagues. However, this were sometimes reluctant to do this when they thought it may burden colleagues who were less senior or had higher caseloads.

When collegial relationships were difficult, however, they were described as "the most difficult and draining thing" (James, principal clinical psychologist, secondary care). Participants spoke passionately of the negative impact that conflicts with colleagues had on their wellbeing, and the time and effort they took to navigate; one participant summarised difficult team dynamics as:

> *Demoralising, and very stressful. And infuriating at times. That definitely has a pretty deleterious effect on your wellbeing, physically and mentally. And your motivation to go to work.* (James, principal clinical psychologist, secondary care)

Even when collegial relationships were civil, they could prove a strong barrier to speaking up about difficulties. Participants spoke of worries about damaging relationships or being "perceived as being quite difficult and resistant" (Asha, clinical psychologist, secondary care) for raising concerns about organisational issues which impacted them. Those who struggled with mental health difficulties feared being seen as weak or less competent, and one participant spoke of the impact of racial stereotypes on their ability to speak up:

> *I was quite assertive, but I felt like she treated me like this, you know, angry black man or something.* (Kofi, PWP, primary care)

Valued formal support structures. All participants spoke of the value of regular, formal supervision for managing their wellbeing. Generally, these conversations began with the educational aspects of supervision and the importance of supervision for feeling competent in their role. However, participants spoke of supervision that was merely case management as unsatisfactory. They spoke of the importance of a "safe space" (Michelle,

newly qualified PWP, primary care) to be "able to reflect on emotions, feelings, concerns, fears with certain clients" (Tom, CBT therapist, primary care).

Participants valued both individual and group supervision spaces, in addition to reflective spaces. Multiple participants shared anecdotes about the importance of having someone with whom to speak about difficult feelings about themselves without judgement.

> *I suppose it probably does at some level…combat a bit of that, like, 'maybe I'm just s*** at this' in supervision because obviously, that's not the conclusion that supervisors come to with you.* (Katie, newly qualified clinical psychologist, secondary care)

Asha shared an anecdote of feeling guilt over irritation towards a client, and speaking openly in group supervision:

> *I didn't feel like anyone judged me. In fact, they were like, 'Oh, this is brilliant Asha, you just, you know, tell us more'…when I shared it, everybody normalised it and said, 'Yeah, people p*** me off, man, like, of course it's annoying, like it's, you're human!'. So there's something normalising about supervision, validating, just reassuring that you're not... sitting with something all by yourself, and feeling like you're this terrible clinician.* (Asha, clinical psychologist, secondary care)

Other elements that were discussed as being important in a supervisory relationship were the benefits of a long-term relationship to build trust and familiarity, and consideration of the individual's career development. One participant spoke of the importance of collaboratively finding solutions and not having a supervisor "pull rank" (Kofi, PWP in

primary care). Some participants spoke of finding particular benefit in having a supervisor who was more senior or more experienced and drawing on this expertise. Finally, Kofi also spoke of the importance of supervision being most beneficial when cultural norms were respected. He reflected on an interpersonal clash with a younger supervisor, and how he was supported with this by a different colleague who offered supervision:

> *"I'm from an African background and there's this thing that we respect our elders….I think [my new supervisor] was like, "yeah, Kofi wouldn't listen to this person". And I think she has experience of working with people from my cultural background as well. So, I wondered if she saw that thing about age".* (Kofi, PWP in primary care)

The importance of supportive management. Supervisors and managers were seen as a vital source of support, and a source of frustration when not accessible. Participants spoke to the availability of managers as essential and highly valued. Managers who created time and who explicitly encouraged therapists to reach out about personal as well as professional difficulties which may impact them were valued. To the contrary, difficulty finding time to meet managers or lack of responsiveness were noted as barriers to getting support.

> *More approachability from the supervisor's point of view would be helpful…just to know that I can have that chat or, you know, five-minute Teams chat or on the phone. It's a bit disheartening, a bit isolating when you don't get a response.* (Jacob, CBT therapist, CAMHS)

Managers were seen as important in setting the tone around wellbeing management in the workplace; speaking about and normalising the impact of therapeutic work on wellbeing

was valued. Participants spoke of sometimes finding it difficult to recognise when they were unable to work, and what was highly valued at these times was managers recognising this and giving express permission for participants to reduce work demands or take time off work to recuperate. One participant reflected on a feeling of disappointment when this was not done by their supervisor, and how they thought that should be addressed.

> *Me saying, "actually, I'm really struggling" should, should have been met with, you know, discussion about "are you OK to work? Are you fit to practise?"...I think as supervisors we need to take a bit more responsibility for saying, "actually, I'm just gonna make the call on this, you know, just go and take a week, go and lie around your bed, eat too many biscuits, come back in a week."* (Liz, clinical psychologist, acute medical setting)

Systemic factors.

The impact of austerity. Participants spoke at length of the noticeable impacts of austerity on the healthcare system, and how this directly impacted their wellbeing in the workplace and also their sense of feeling valued by the healthcare system. Participants spoke about the numerous ways that underfunding affected their day-to-day work. Largely, understaffing and a lack of resources led to participants feeling highly stressed, less able to take breaks to seek support or rest, and more likely to work extended hours or take work home. Furthermore, many examples arose of participants "filling gaps, and maybe working outside of remit" (Mark, CBT therapist, primary care), and additional stress as participants worked outside their competence. Multiple participants spoke to the impact of the pandemic and Brexit on staffing levels and resources.

Furthermore, participants spoke of salary increases not matching inflation as exacerbating feelings of being "unappreciated, sort of undervalued, overworked", and that the July 2022 pay rise felt like a "slap in the face" (Asha, clinical psychologist, secondary care). Issues around salary resulted in feelings of bitterness and resentment.

> *It is very hard to not feel bitter when you think, hang on, you know, I have less and less each year than I, than I did by, by cost of living and yet I'm more and more skilled each year.* (Liz, clinical psychologist, acute medical setting)

In addition to salary, many participants spoke of the importance of small tokens in feeling appreciated by their employer. Non-provision of tea, coffee, and milk in particular was seen as a marker of the lack of appreciation. This was compared to the feeling of value when companies offered discounts and free items to NHS staff during the pandemic. One participant spoke of the message these tokens conveyed to staff about their wellbeing:

> *If you're given a free tea and coffee, there's a message of 'take a break, have a cup of tea, treat yourself to a biscuit. You're worth it'. Like, you know, just take a few minutes, gather yourself…I think that's for me what it felt like.* (Asha, clinical psychologist, secondary care)

Wellbeing at the team and Trust level. Therapists spoke of a variety of factors within their teams and organisations that contributed to increased stress levels. Often, these were stressors that were exacerbated by underfunding. Participants spoke of long waiting lists and needing to take on high caseloads, which had a knock-on effect of having insufficient time to reflect on their client work, debrief with colleagues after difficult sessions, and manage

administrative tasks such as writing notes. Time pressure was discussed as a barrier to seeking support with wellbeing. Participants spoke of feeling other teams were less likely to accept referrals or support in an effort to protect their own resources, which created stress around the "politics" (Steven, clinical psychologist, forensic service) between teams. Furthermore, services which had targets around sessions-per-week or recovery rates were cited as a particular source of stress, which participants did not feel fit with their values around or the realities of therapeutic work.

> *Even though my clients won't go, won't hit IAPT's version of 'recovery'…clients will still thank me. They will still take things away from it.* (Tom, CBT therapist, primary care)

The target-driven nature embedded within the IAPT model was often referenced as something which negatively impacted wellbeing by applying high demands, contributing to stress and burnout. Participants who discussed working in services with less focus on targets referenced this as something they valued.

Further to this, lack of investment in adequate facilities in NHS buildings was seen as a reflection of the lack of meaningful consideration given to basic needs at work. Participants discussed buildings with faulty plumbing, inadequate IT, and insufficient access to desks and stationery. This was often contrasted with Trust wellbeing initiatives, such as brief massages, yoga workshops, or wellbeing talks. These initiatives were spoken of as at best glib, poorly thought out, and evidence of a lack of consultation with workers about what they needed. At worst, these initiatives were seen as "individualising" (Katie, newly qualified clinical psychologist, secondary care) the impact of stressors caused by long-term underfunding.

It's sort of more basic needs stuff…just getting a kettle for the office, for example…that's lovely we've got, you know, a six-week mindfulness course at one of the hospitals. But as a team, yeah, we don't actually have a printer. (Steven, clinical psychologist, forensic service)

They're saying "here's all the things we can provide for your mental health, but actually we're going to continue having a system that crushes you in other ways". So, it's kind of like "here, there's too much work, there's systemic understaffing, there's a Tory government. But hey, you can have free ice cream every Friday", you know? (Liz, clinical psychologist, acute medical setting)

Facets of a supportive organisational culture. Participants also spoke about how organisational culture across a team or directorate – rather than just relationships with individual managers - can either support their ability to manage wellbeing, or create a barrier. Participants spoke of the importance of being treated as an individual; permission to balance personal commitments (e.g. childcare and healthcare appointments) alongside the needs of the service were seen as important for wellbeing, as was prioritising individual career development. Participants who felt micromanaged found this stressful and infantilising, whereas those who felt respected as autonomous and competent professionals valued this attitude.

I really respect that our managers trust that they've hired the right people and leave us to get on with it. And that's, that's a really big part of choosing to stay for this Trust as well. (Liz, clinical psychologist, acute medical setting)

A culture of normalising the challenging nature of therapeutic work was seen as essential. Primarily, participants spoke about the importance of a shared understanding that emotional responses to the realities of therapy - such as exposure to distressing material and complex interpersonal dynamics- were an inevitable reality and that disclosing these feelings in work were a "sign you're doing the job well because you are aware and reflective as a practitioner" (Steven, clinical psychologist, forensic service). Organisations which created space for explicit discussions about this, such as Schwartz rounds, were seen as prioritising staff wellbeing. A supportive culture was also evidenced by non-individualising, non-blaming responses when issues with clients arose, such as risk issues.

> *We work with such risk in my team, I think if something did happen - an incident - you don't want a team to be like, 'Oh, OK. Well, what did you do wrong?' You know? 'Why did this happen?' I think a culture of just being compassionate and understanding. Just a real acknowledgement for the hard work that we do*. (Asha, clinical psychologist, secondary care)

One participant spoke of the importance of not only a culture which normalised emotional responses, but also emphasised the value of their work. Teams which took time in team meetings to reinforce positive outcomes of individual therapists or beneficial work their team had done were valued. This was integrated into the organisation by requesting feedback from clients or colleagues to share with therapists.

Consequences of the COVID-19 pandemic

How the pandemic impacted work-related wellbeing. Participants had vastly different experiences of working during the pandemic; some experienced a sudden shift to entirely

remote work, whereas others continued conducting in-person sessions in hospitals and clinics. However, common narratives were identified.

First, participants spoke of the drastic changes to their working life and the increase in workload the pandemic brought with it. One participant reflected that they "probably worked more than [they had] ever worked before" (Tom, CBT therapist, primary care). This was due to a combination of learning new protocols and adjusting services, increased referrals, and increased staff absences. Participants spoke of feelings of disconnection, exhaustion, and difficulty supporting a full caseload of clients. Some experienced the deaths of both colleagues and clients.

> *It was also just a really stressful time, like loads of people off sick, just really stressed - the most stressful I think I've been working in the NHS. Most stressed I've been.* (Asha, clinical psychologist, secondary care)

This was compounded for participants by an inability to utilise the activities and support structures they usually would. One participant spoke of a Trust-wide ban on leave being taken, and others spoke of the inability to turn to valued informal debriefs and camaraderie in the workplace with colleagues. Furthermore, lockdown restrictions led to a restricted ability so socialise with friends outside work. For those living with family, the significant uncertainty at the physical risk posed from COVID led to isolation from family members in an attempt to protect them. One participant working in a hospital setting spoke of this fear and concern around mortality:

> *Looking back that would be really hard to explain to somebody that wasn't there, because they'd think well that's really extreme cause most of us have had COVID*

> *now…actually back then that was when there was incredibly quickly rising death tolls and pictures of, you know, people in Italy on ventilators and people, you know, trucks of bodies being taken out of Berlin. So, the first 6 to 8 weeks, most of the colleagues that I was in the hospital with, and I did think we might be dead within the next month to two months. So, it was a very, it was a very odd time to do that. Lots of things, like phoning my husband when I was getting out of the car so you can get the kids and make sure that they're in the living room, so there's a free run from me to streak from the front door to the bathroom without touching anything. (*Liz, clinical psychologist, acute medical setting)

Some participants also spoke of a feeling of being improperly supported by employers or managers. Liz remembered the anxiety caused by being sent to work with no personal protective equipment, and needing to purchase and use their own cleaning products to maintain their safety.

The introduction of remote working and its consequences. Participants who had worked remotely had different experiences depending on their personal circumstances and the point during the pandemic. Generally, remote working was largely experienced as detrimental to wellbeing early in the pandemic and during lockdown periods. Participants spoke of a lack of familiarity with delivering remote work and few protocols in place which led to feelings of uncertainty and lack of confidence. Participants reflected on feelings of isolation from colleagues and support structures during this period, especially as organisations did not have the technology to support a sudden shift to remote work. Even once remote platforms (such as Zoom and Microsoft Teams) had been integrated, participants spoke of the "surreal, almost kind of plastic edge to everything" (James, principal clinical psychologist, secondary care) that only speaking to others remotely had. Participants also

spoke of a lack of routine at this time, with some sleeping in until their workdays began or working in pyjamas. Finally, remote days were likely to invoke ‘Zoom fatigue’ as there was no break in screen time.

Individual living circumstances impacted the experience of remote working. For example, participants with caring responsibilities spoke to the challenge of juggling this with working responsibilities. Additionally, participants who had access to a separate space in which to work felt this was beneficial and upheld boundaries between personal and professional lives. Those with limited space or who lived with others found this more challenging, as they were exposed to distressing material in their personal spaces like bedrooms. This contrast is demonstrated by the following therapists with different living situations:

> *I'd come out with an online session at home, having done, like reliving of some childhood abuse into my living room with my housemates who were all like furloughed or talking about something corporate like, it was really jarring.* (Katie, newly qualified clinical psychologist, secondary care)

> *From a purely selfish point of view - I like working from home, but I'm also very lucky that I have a study that I can lock, and I don't have to see it over the weekend, and I have the space to do that, whereas I think a lot of people who are in shared houses or in sort of very small places, they don't have that.* (Michelle, newly qualified PWP, primary care)

Whilst supervision was considered to translate well online, participants also spoke of the reduced access to ad-hoc support when colleagues were not physically available and one

could not “just knock on the manager’s door” (Jacob, CBT therapist, CAMHS). Some spoke of finding it more difficult to reach out for support as they perceived sending an email requesting a chat more formal than speaking in person would be.

> *The threshold that it takes to come out of a difficult therapy session and walk into a room of your mates, and go ‘Ugh. That was a bit grim, I'm not sure that went so well’… that just wasn't there, you know?* (David, psychotherapist, primary care)

Participants also noticed benefits of shifting to remote working, particularly later in the pandemic as remote platforms were set up and lockdown restrictions eased. Participants spoke of increased social and leisure time from not commuting, and were spending less money on travel. Some participants also spoke of increased access to support as they could access specialist supervision or meet with colleagues based further afield. Generally, most participants shifted to in-person therapeutic work once the option became available but worked remotely for meetings and administrative tasks. This hybrid approach was seen as beneficial for managing wellbeing. Participants found ways to manage earlier difficulties, and spoke of ensuring they had routines before or after work, and changing clothes to psychologically switch between work and relaxation time. Broadly, participants found having hybrid working options post-lockdown permitted choice and flexibility, and allowed for enhanced work-life balance and greater opportunities to engage in activities which enhance wellbeing.

> *It feels much more balanced. I literally cannot imagine working face-to-face in the office five days a week anymore. So, I think in terms of wellbeing having the option to do some stuff from home is bloody great. But equally, it's almost felt really like getting*

back to the job that I kind of had originally been doing. (Katie, newly qualified clinical psychologist, secondary care)

Discussion

In this research, I aimed to explore factors which impacted the wellbeing of NHS psychological therapists, the sources of support they most valued, barriers to accessing these, and any changes which had resulted from the pandemic. Broadly, the results of this research fit with previous literature. Consistent with literature around burnout and compassion fatigue, participants confirmed the emotionally challenging nature of working with the distress and trauma of others. They acknowledged that this could have both a short- and long-term impact on their wellbeing. Participants expressed a greater difficulty recognising longer-term impacts, however, and were more likely to reference anecdotes about their exhaustion or low feelings of personal accomplishment than explicitly link these experiences to compassion fatigue or burnout. In line with Larsen & Stamm's (2008) literature on compassion satisfaction, participants also discussed the pride and satisfaction they received from observing positive outcomes for clients and those in their networks. Furthermore, they discussed enjoying the mental stimulation of their work. The findings of this study add further nuance to existing literature; for example, early career therapists have been shown to be more susceptible to burnout (Ackerley et al., 1988; Lerias & Byrne, 2003). The present findings suggest this may be due to the sudden increase in clinical responsibility after qualification, as well as having less experience managing risk issues which creates additional anxiety and stress. Additionally, this research indicates that, perhaps unsurprisingly, therapists appeared to be an insightful group about the short-term impacts of work-related stress and personal strategies they use to manage them. However, the results go on to highlight that the impact of chronic exposure to human distress and high work demands is

less noticeable over time and participants spoke less of awareness of psychological symptoms of this (for example, burnout). They also provide new insights into therapist wellbeing in the context of the pandemic and moving towards pandemic recovery. They highlight the variety of experiences of therapists working during the pandemic: exposing themselves to significant physical risk when working on site; the blurring of boundaries between personal and professional lives when working remotely; and the new insights of potentially improved balance between work and home lives with the advent of hybrid working. Generally, these results are in line with other literature investigating therapist experience of working during the pandemic (Billings et al., 2021; Morgan et al., 2022). However, they provide updated insights as the NHS moves out of the initial crisis of the pandemic and into the recovery stages, including the 'new normal' of hybrid working. Furthermore, extant literature indicates female therapists are more susceptible to burnout and compassion fatigue (McCormack et al., 2018; Sutton et al., 2022; van Hoy & Rzeszutek, 2022). This is possibly as women generally take on more domestic and emotional labour than men. However, in this study no clear differences between men and women were identified. Regardless of gender identity, participants who were parents both spoke of the significant challenges of balancing work and home lives. It is possible that this is a result of remote working supporting more equal divisions of domestic labour; however, this cannot be extrapolated from the results of this study and should be the focus of further research.

Additionally, this study contributes to the literature by highlighting the profound impact that societal events which impact the NHS as an organisation (i.e. Brexit, COVID-19, and austerity) have on those individuals working within it. The results of this research can be understood using Bronfenbrenner's (1979) ecological systems model. This model postulates that there are four systems in an individual's environment which influence their development and wellbeing: the micro-, meso-, exo- and macro-systems (see Figure 2). The microsystem

here refers to the therapist as an individual, and the strategies they use to manage their personal wellbeing, such as hobbies, rest breaks, and accessing personal therapy. The mesosystem can be considered as their direct team; the interpersonal dynamics within their team, the culture of discussing wellbeing, and the quality and availability of support from supervisors and managers. The exosystem can refer to both individual NHS Trusts, and the NHS as an organisation. This incorporates workplace demands such as allocation of funding for teams which impacts staffing levels and workloads, the standards and targets imposed on services, and adequate facilities. Finally, the macrosystem is the social and political climate of the UK. This encapsulates governmental policies (both decisions which impact the NHS directly such as funding, but also policies which may impact social determinants of health and thus dependence on the NHS) and societal events such as Brexit and the pandemic. Ultimately, maintaining therapist wellbeing is dependent on a complex interaction between all of these systems. The use of this model can be used to inform NHS Trusts in how to structure wellbeing interventions. As found in this study, focussing heavily on individual wellbeing (e.g. self-care initiatives) can be received by staff as individualising. It would also be beneficial to acknowledge the impact of systemic factors on individual wellbeing to move away from a narrative of locating distress within individuals. Trusts should invest resources in tagetting the meso- and exo-systems; for example, improving the working environment and resources, supporting team-based initiatives such as training or reflective spaces, and considering changes at the organisational level which can support therapist wellbeing. As identified in this study, consulting with staff about their needs would be beneficial, as would be feeding back how Trusts have made efforts to meet their needs.

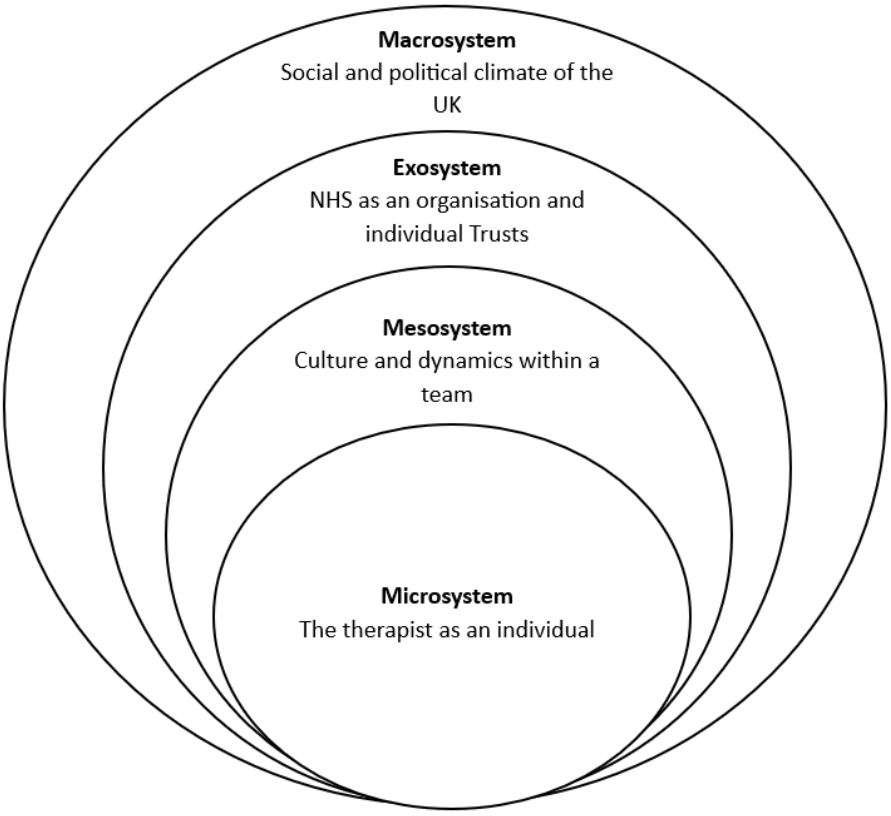

Figure 2.

Ecological systems model of factors impacting NHS therapist wellbeing.

Impact of working conditions on individual wellbeing

This research adds to the literature by highlighting the detrimental impact of sustained austerity, understaffing, unsustainable job demands, decreasing relative pay and sub-standard working conditions have on psychological therapists. As discussed, these have been found to contribute to burnout and job attrition in healthcare professionals more broadly (Bimpong et al., 2020; Dobson, 2023; Kirby, 2023) and the results of this study have shown that this is also evidenced in psychological therapists. The present findings highlight how working conditions have a damaging impact on therapist wellbeing at every level. On a personal level, therapists discussed feeling undervalued by dwindling salaries, and yet experiencing a continued pressure to accept more demands to the point of working outside their competence. It is possible, given other evidence suggesting NHS working conditions contribute to staff

attrition, that if these are not addressed, this will continue to perpetuate a cycle of therapists who feel burnt out, undervalued, and leave the NHS. On a broader scale, participants spoke of overwhelm at increasing caseloads, understaffed teams, and an expectation to take on additional demands and work outside of their salaried hours. Sources of frustration included having inadequate basic equipment and facilities to perform their job, such as clinic spaces, desks, and functioning facilities.

The importance of relational connection

The results of this study echo previous research around therapist wellbeing by highlighting the importance of various sources of interpersonal support to therapists (Sutton et al., 2022; van Hoy & Rzeszutek, 2022). Seeking informal support from colleagues (either in-person or virtually), or more formal sources of support such as supervision, reflective practice, and support from management were cited as a valued and powerful mechanisms to maintain wellbeing at work. Participants reflected on time with colleagues as a source of education and development, somewhere to debrief after difficult sessions, and also a source of pleasure and camaraderie at work. Consistent with previous research, participants saw supportive collegial relationships as protective against burnout (O'Connor et al., 2018). Supervision was discussed as a place where challenging feelings invoked by their work, such as interpersonal difficulties or imposter syndrome, could be expressed openly and validated. Supervisors and managers also played a key role in providing support to manage acute job demands (e.g. support with risk management, or support to reduce caseloads). However, when relationships with colleagues were stressful this contributed to impaired wellbeing or blocked access to support. Stigmatising views, difficult interpersonal dynamics, and lack of availability by management were discussed as sources of frustration for therapists.

Where participants suggested changes that could be made to enhance their wellbeing, often interventions which aided social connection and team cohesion were discussed. This included space in one's diary which could, if required, be used to socialise or debrief with colleagues, or team away days. It was also noted that supervision was most effective when relationships with supervisors were positive, supportive, met cultural needs and, where possible, long-term. Finally, more availability from managers either in the form of drop-in availability or virtual responsiveness was desired.

Clinical Recommendations

Based on the findings of this study, a number of clinical recommendations which are important for enhancing therapist wellbeing are suggested:

1. Team coherence and colleague dynamics were of vital importance to the participants in this study. To this end, creating flexibility within the workday to allow for colleague support, in addition to arranging regular team-building events such as team lunches or away days, should not be seen as a superfluous or at odds with the aims of mental health teams. Rather, they are vital to allow time for colleagues to build relationships, share knowledge, and support each other. Within this, there is evidence that formal support structures such as peer supervision, reflective practice, and Schwartz rounds are helpful interventions that can increase collegial compassion and connection, improve workplace support and thus job satisfaction (George, 2016; Rothwell et al., 2019). This was reflected in the current study, where reflective practice spaces were valued by participants. However, whilst these are important for team cohesion, they are not sufficient. It should also be noted that personality clashes, difficult dynamics, and bullying can arise in any field, and therefore it is important that colleagues are properly supported to manage such challenges. It is important that

employers have policies to manage these, and therapists may benefit from dedicated support in managing difficult dynamics and support with conflict resolution.

2. Managers have a key role in shaping the culture of teams. Essential facets of a supportive team culture include open conversations around the emotional impact of therapeutic work, supporting the individual to balance their personal and professional lives, and supporting career development. Managers should support therapists to be autonomous practitioners, and create a culture where staff wellbeing is openly discussed. Reflective practice spaces or Schwartz rounds are examples of forums which have been evidenced to create this.

3. To avoid placing the sole responsibility of supporting wellbeing within the team on managers and to maximise collegial support, NHS England have introduced the role of health and wellbeing champions (NHS Employers, 2022b). These are individuals within the team who have additional training in promoting wellbeing conversations within the team, and signposting colleagues to support systems. This is one example of how teams could integrate peer support around wellbeing.

4. This study indicates that therapists may find short-term impacts of stress easier to identify and manage than longer-term impacts, such as burnout, compassion fatigue, and vicarious traumatisation. It would be beneficial for teams to provide regular training around these to support therapists to recognise risk factors and symptomology. This has been found to be protective against vicarious traumatisation in other studies (Sutton et al., 2022). Furthermore, teams should create space for therapists to discuss their experiences around this confidentially (for example, in

supervision).

5. Employees require adequate facilities to be able to properly complete their work; investment is required in adequate buildings, working IT, sufficient desks and clinic spaces, and access to essential office equipment.

6. Remote and hybrid working are valued by some therapists as supportive of a healthy work-life balance, although this is not unanimous. This indicates that employers should provide flexible options so that therapists can chose a working pattern which balances their personal circumstances with client needs.

7. Therapist wellbeing may be improved by moving away from target-driven performance indicators and audits of time. Allowing flexibility within the working week would allow them to complete administrative tasks, manage client-related crises, or give time to decompress and discuss their work with colleagues. However, client waiting lists in the NHS are currently long and clients are in distress while waiting for support. Therefore, to allow for this, investment is needed in training, employing, and retaining a sufficient number of therapists.

8. Organisational wellbeing initiatives should involve consultation with teams about what interventions they would find most useful and any investment of funds should be tailored to what teams believe would be of most benefit to them.

Strengths and Limitations

The present study benefits from a broad sample of psychological therapists from different geographical regions of the UK. Therapists ranged in age, professional background, and seniority to maximise the transferability of the findings. Furthermore, the sample was predominantly (57%) male. This is highly unusual for research into therapist wellbeing, which is broadly female-dominated. However, gender differences have been found regarding how therapists experience burnout (van Hoy & Rzeszutek, 2022) and vicarious traumatisation (Lerias & Byrne, 2003) and therefore it is beneficial to include a range of experiences. This research did not indicate any differences in burnout or vicarious traumatisation, although specific questions around these experiences were not asked. Additionally, although purposive sampling was used to try to recruit Scottish therapists, none participated. The study would have benefitted further from including their perspectives; for example, annual healthcare spending in Scotland has increased less than in England and therefore the impact of healthcare underfunding may have been more salient (Farquharson et al., 2021).

While the study sought to understand wellbeing broadly, it is limited as questions were not asked about some areas of marginalisation. Some participants did speak to their experience as racialised individuals, or as those with personal experience of mental ill-health. However, it is possible other participants had experiences of marginalisation which impacted their wellbeing as therapists but did not disclose these as they were not directly asked about them, or due to our voluntary sampling procedure, we did not capture the views of potentially marginalised groups. Understanding the wellbeing of therapists from these groups is essential. A study of Black therapists in the USA identified cultural racism as a predictor of burnout, meaning this group may be at even greater risk of impaired wellbeing (Shell et al., 2022) than white therapists. This is likely to be reflected in UK therapists of minoritized ethnic backgrounds following the pandemic. Following the murder of George Floyd in 2020 and resultant Black Lives Matter protests, there was an increased awareness of and

discussions both within and outside the workplace about cultural racism within the UK. Furthermore, as individuals from minoritized ethnic groups are exposed to multiple structural inequalities they also were at greater risk of COVID-19 exposure, acuity, and mortality than white individuals (Bentley, 2020; Bhatia, 2020). These experiences contribute to minority stress, and thus it is likely that minoritized therapists in the UK have similarly impaired wellbeing compared, especially if they are supporting clients through the same traumatic context (as in found by Culver et al., 2011, and Lambert & Lawson, 2013). Furthermore, therapists with lived experience of trauma have been found to be more susceptible to vicarious traumatisation (Peled-Avram, 2017). Further research specifically investigating the impact of marginalised identities on therapist wellbeing would be of benefit in understanding if differential sources of support are needed for these individuals or if they face additional barriers.

Additionally, therapists in certain work settings spoke to additional pressures that are not necessarily transferrable across all therapists. For example, forensic practitioners spoke to the nuances of working with incarcerated individuals, those who were perpetrators of crimes against others, and awareness of the needs of victims. Those who worked in IAPT services spoke of the significant impact of meeting caseload targets, something which is integrated into a high-volume service model. Whilst it was important to include these practitioners in this study to capture a range of therapist experiences, it would also be beneficial for future research to exclusively investigate the pressures particular to these professionals.

Conclusion

This study investigated the factors impacting NHS therapist wellbeing, the sources of support they found most beneficial, and any barriers to these. Largely, the findings supported existing literature around the emotional impact that delivering therapy can have on the therapist, as well as feelings of achievement and compassion satisfaction. The study adds

further nuance as it indicates that while experiencing an abnormal exposure to distress and managing client risk, therapists often felt able to manage this with collegial, supervisory and managerial support. What they felt was less manageable was the consequences of working in an underfunded healthcare service, especially with high waiting lists and staffing pressures following Brexit and COVID-19. NHS therapists found inadequate facilities, inadequate resources, unrelentingly high job demands and a sense of being underpaid and undervalued significant stressors. Furthermore, overwhelmed work schedules created barriers to accessing support.

Considering these results using the ecological systems model, it suggests therapists are aware of and will utilise strategies at an individual level to manage their wellbeing, and are aware of some sources of support within the workplace. However, maintaining wellbeing and thriving at work is not possible if only one system of the model is functioning well. Many of the clinical recommendations in this paper require systemic investment in the healthcare system to provide adequate staffing, facilities, and reduce workplace demands. Ultimately, individual self-care strategies, supportive teams, supervisors and managements, and Trusts which prioritise wellbeing are essential but not sufficient for NHS therapists to thrive at work and manage wellbeing. It is essential that colleague relationships, organisational culture, and supportive supervisory relationships are in place to support therapists. However, to combat the crisis of retention in the NHS and retain expertise, it is vital that the government invests in the healthcare system.

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Part 3: Critical Appraisal

In this section, I will critically appraise my experience of the process of engaging in the research presented in Parts 1 and 2 above. I will first introduce my relevant professional background and experiences of working as an NHS-based psychological therapist from immediately before the pandemic began to the present day. Following this, I will reflect on how my personal experiences attracted me to this topic and informed my research questions. I will also discuss how work on placement informed my academic understanding of this topic, and vice versa. Finally, I will also talk about challenges within the research process; both the academic challenges of the process of conducting a systematic review, and the personal challenges of professional and life stressors, their impact on my wellbeing, and the experience of researching a topic relevant to my experiences.

Professional background

The majority of my pre-qualified career has been spent in paid and voluntary roles in the NHS, since 2010. My final job before starting clinical training began in September 2019, working as an assistant psychologist in a secondary care mental health service. In this role, I was based in the office with my colleagues daily until March 2020, where I was permitted to do two days per week remotely due to possible clinical vulnerability (asthma). My experience of remote working did not begin in earnest until September 2020, when I moved to London to commence my training. All teaching and my year-long IAPT placement were remote for my entire first year. This resulted in me delivering therapy, receiving supervision, and engaging in teaching from a small desk next to my bed for my first year.

Restrictions began to lift in the middle of my training, and I began hybrid teaching and placements from second year onwards. I was given flexibility to request an elective final placement. I requested a leadership placement in staff wellbeing, and was fortunate to be

allocated within my interests. At the time of writing, I am in a large team of psychologists in an NHS-based staff wellbeing service, delivering one-to-one interventions and working as a systems level to facilitate wellbeing interventions such as reflective practice and support shifts in organisational culture.

Reflections on empirical paper

What drew me to the topic.

My cohort selected our thesis topics in February 2021, in the first half of our first year. I had worked entirely remotely for five months at this point. I worked from my bedroom as I shared a flat with other remote workers. England was in lockdown at this point (Institute for Government, 2022). The seeds of my thesis topic were sewn via conversations with colleagues and peers within the profession around the experience of managing our own experiences and traumas relating to the pandemic, but also being the source of support for our clients at this time. I became curious about the impact of supporting clients while living through the same traumatic context. Typically, in my professional experience there was encouragement to not support clients with topics that felt too close to home. However, every therapist and every client were impacted by the pandemic in some way and it became impossible to do this. I was concerned about the impact of exposure to emotional and distressing material in one's personal space, and the ability this had on a therapists' ability to maintain boundaries between their personal and professional identities. I began producing a proposal around the impact of the pandemic on therapist wellbeing.

My ideas for the project developed as pandemic restrictions began to lift, and my supervisor encouraged me to consider the timeline of the research and think about maximising the utility of my project long-term. We acknowledged the vital importance of research conducted during the acute phase of pandemics; indeed, one of the key papers I

reviewed in the early stages of development was a meta-synthesis by my external supervisor of previous pandemics (Billings et al., 2021). I am however grateful that I was encouraged to broaden the scope of my research question as the project has been completed a year after final pandemic restrictions were lifted. These conversations allowed me to shift the focus of my research from the specific impact of the pandemic on wellbeing to understanding therapist wellbeing more broadly. Given the adjustment to the 'new normal' of remote and hybrid working and the pressures on the NHS following initial waves of the pandemic, I maintained questions around this to reflect wellbeing in the modern workforce of therapists as society recovers from the pandemic.

Before I began data collection for my empirical paper, I had hypothesised that the predominant findings of my thesis would be around the emotional impact of delivering therapy and working with distressed individuals. From my own insights as an insider researcher (Hayfield & Huxley, 2015) and from the literature around compassion fatigue, compassion satisfaction, burnout, and secondary traumatic stress referenced in Part 2, I predicted that these would form the bulk of my results. Initially my decision to only include NHS therapists was related to my questions around sources of support and barriers to accessing them. As privately practicing or third-sector employed therapists may work independently or in very different organisational structures, I sought to keep my participants relatively homogenous in their employment. This proved a serendipitous decision, as my analysis identified themes around the considerable impact of austerity and NHS underfunding on therapist wellbeing. These results reminded me of an impassioned discussion from one of our psychodynamic seminars, discussing the chapter '*Neoliberalism is bad for your mental health'* (Bell, 2019). This chapter discusses capitalism and the impact of neoliberalism on mental health services. The author reflects on impact on services of stripping back resources and the continued drive for productivity and economic benefit. Re-reading this paper after

data analysis, I was struck by the mirroring between a quote from this chapter and one of my participants about the trickle-down impact of stress around targets:

> *"This atmosphere of threat of punishment (for example through not meeting targets) flows downwards through the system creating severe anxiety at every level."* (p.12, Bell, 2019)

> *"I think that's where a lot of that stress comes from. So if management's stressed about meeting those targets then they're gonna pass that stress down on to everyone that's trying to meet them, essentially…I think something needs to change there, because I think that's ultimately where it's coming from."* (Lucy, newly qualified PWP, primary care)

The conclusion of this chapter is around the damage that the current target-driven culture of the NHS has, and the prioritisation of financial bottom lines and quantifiable outcomes over therapeutic relationships is at odds with the foundational values of the NHS. I recall in this seminar sharing my own experiences of the difficulties, especially on my IAPT placement, of providing meaningful, client-centred care whilst also balancing strict session limits, recovery targets, and an awareness of long waiting lists.

Furthermore, many of the themes of the empirical paper not only reflect my own personal experience as a therapist in the NHS but have provided scope for concern and reflection about my future career. Like all NHS professionals, I have been impacted by inadequate resources, understaffed teams, and below-inflation pay increases. A quote from one participant which struck me in particular was as follows:

> *It is very hard to not feel bitter when you think, hang on, you know, I have less and less each year than I, than I did by, by cost of living and yet I'm more and more skilled each year.* (Liz, clinical psychologist, acute medical setting)

As an individual on the precipice of a career as a qualified clinical psychologist within the NHS, I found it difficult not to feel a sense of hopelessness. The realisation that my colleagues and I would become more experienced and valuable to the NHS every year, and yet by the current trajectory we would earn less in real-terms each year was sobering. This became a point of discussion in both clinical and research supervision over the following weeks. However, it also imbued me with an enriched belief in the importance of this research and of presenting a case for the importance of looking after and maintaining therapists within the NHS.

My own health and wellbeing impacted

In addition to commencing training during the pandemic and experiencing changing restrictions and lockdowns during my first year, I experienced a number of challenging personal circumstances. I was anticipating that clinical training and balancing clinical and academic responsibilities would be a challenging period of my life. However, I had been unable to predict personal stressors and found myself during my first year balancing clinical and academic commitments in addition to a full-time caring role for a loved one. This unfortunately came during a lockdown, when most social and leisure activities were unavailable to me. This chronic high level of demand at a time when access to support and recreation was limited had an impact on my health. After contracting COVID-19 myself at the beginning of my second year, I became trapped in a cycle of recurrent chest infections, running low on my required placement days due to sickness, and being unable to take annual

leave to restore myself. After a year of this, course staff helped me to recognise this cycle and what I now recognise to be burnout which impacted my health. I was encouraged to take an interruption of studies and extend my training contract to give me chance to recover. When I reflect on this period, it is impossible not to notice the parallels between themes identified in my research and the support required during this period. Reflecting on my participants struggling to notice chronic impacts of stress helped me recognise this in myself. Although I could recognise stressful days and would engage in hobbies, and seek supervision or social support, it took supportive management to help me to recognise my own burnout from extended chronic demands. I was unaware of what support, such as an interruption of studies, was available to trainees. Benefitting from a line manager and course tutor who had open and honest conversations about wellbeing and presented options to support me was essential for my recovery. Furthermore, it highlighted to me that personal management of wellbeing is essential but not sufficient in managing work stressors. In this instance, the pressures of the system that I was working within (for example, academic deadlines and required minimum placement days) only had limited flexibility, and I unexpectedly became a case study of the topic in which I was researching.

Reflections on systematic review

During the planning stages of my thesis, I was motivated to use the experience to fill in gaps in my knowledge and research experience. An awareness of these gaps was helpful in guiding my choice in methodology. My previous research experience had been predominantly quantitative, which led me to pursue a qualitative thesis, and when faced with the choice between a conceptual introduction or systematic review I opted for the latter to increase my research skills. Whilst learning to conduct qualitative research felt like an

appropriate and manageable academic challenge to navigate, the process of conducting a systematic review proved significantly more difficult.

My most lengthy but unexpected challenge came with selecting a topic for my review. This highlighted a large gap in my abilities as I struggled to navigate databases of literature such as PsycINFO. Despite utilising resources provided by course staff and the university library, I struggled to understand when I had adequately refined my search terms. I experienced numerous times the frustration of identifying a topic idea and spending multiple study days scoping the literature to eventually find it had already been completed. There is a narrative around trainee clinical psychologists as a group who experience perfectionism at high levels, something I personally identify with. Trainee perfectionism is also associated with increased risk of burnout (Richardson et al., 2020). I began to notice the anxiety that was aroused when I sat down to work on my systematic review, and this began to influence my behaviours. Especially noticeable was avoidance, a common maintenance cycle in anxiety. I would shift my focus to my empirical paper where I was making more consistent progress. This came with the inevitable cycle associated with anxiety; short-term relief, but I continually building background anxiety at the lack of progress made with my systematic review.

My experience of seeking help speaks to the results of my empirical paper; the support of colleagues became essential, and addressing my anxiety and avoidance through collegial and supervisory support became essential for making progress. I discussed this as a significant academic challenge during my developmental review with my course tutor, who validated my difficulties and helped me to breakdown the overwhelming issue of 'finding a topic' into smaller, more manageable steps. The first of these steps was understanding how to effectively use databases. I arranged meetings with the university librarian, who not only demonstrated to me how to navigate databases but also where my search terms were too

broad and capturing irrelevant literature. I was privileged to have an open and supportive relationship with my research supervisors. Despite my perfectionistic anxieties about sharing an area of challenge, something which often discourages trainees from disclosing their personal difficulties (Grice et al., 2018), again being open about my anxieties and concerns allowed for progress to be made. They shared with me guidance about how to do scoping reviews and how to build on previously conducted literature. After many months of frustration and anxiety, these sources of support helped me to identify a topic by January 2023. Colleague support was also essential to this process; forming a supportive group with other trainees in my cohort conducting systematic reviews, in addition to support offered by a colleague from my Masters course, aided me to navigate smaller challenges in the research process and ensure I could continue making progress between arranged supervision meetings.

The topic of my review – burnout – also became the focus of some personal reflection on my own wellbeing. The challenges I underwent with my systematic review increased my working hours as I attempted to make up the months lost struggling to find a review topic. Learning the required skills of a methodology I had no previous experience with, alongside completing my empirical research, three days per week on placement, and experiencing a number of personal difficulties placed significant demands on me. Although my line manager had helpfully recognised symptoms of burnout in me and supported me to take time off to recover, conducting research into this topic gave me a framework to recognise this in myself and the language to seek support for it. I began to recognise the fatigue, irritability, frequent viral infections and sleep difficulties as emotional exhaustion. I acknowledged when my sense of personal accomplishment as a researcher began to dwindle, and this aided self-compassion around this feeling. During one particularly difficult week, I made a cynical and irritable comment to a friend about a piece of work I genuinely valued on placement. This instantly brought to mind the construct of cynicism, and helped me to recognise that I was

struggling. Having the conceptual framework to recognise this in myself expedited the process of reaching out to supervisors to consider where I could reduce demands. I was also encouraged in this instance to take a weekend off from research to relax; this permission-giving from supervisors mirrored findings of my empirical paper, and again reflected the importance of supportive managements and supervisors.

Although I found the research process an aversive one, overall conducting this review was of benefit to my education and did meet my initial career objectives. After completing the project, I not only feel I have filled the aforementioned gaps in my abilities, but I noticed an awareness of the process significantly improved my ability to interpret results of others' systematic reviews. Furthermore, the choice of topic has proved incredibly valuable for maintaining my own wellbeing and for my clinical practice, as I will describe below in my reflections of working in an NHS staff wellbeing service.

Reflections on working within staff wellbeing

My final placement is in a large NHS staff wellbeing service, which has proved an incredibly valuable experience during the research process. My clinical experience has informed my understanding of the theory I have discussed in Part 1 and 2. In an early draft of my systematic review, written before starting my final placement, I confidently wrote that organisational factors such as organisational culture are much more modifiable than person-centred factors. I maintain that these are more malleable than age, gender, or personal histories, however after starting placement I revisited my supervisor's feedback. I was encouraged to revise this section and reflect on the difficulty of changing organisational factors. I was struck by how flippant my statement had been. Part of the work I am directly involved in or have observed colleagues' involvement in is around culture change, team dynamics, and racial equity work. The level of knowledge, strategy, and skilful conversations

required to even highlight these issues as something which could change is significant. The experience of being part of the team delivering these changes adjusted my understanding of the realities of modifying organisational factors.

Although I support non-therapist healthcare professionals, my thesis research has greatly informed my clinical practice. As I reflected in an earlier section, even having a framework and the language to explain the impact of healthcare work on healthcare professionals is a surprisingly powerful intervention in itself. Supporting clinicians to consider their disengagement and frustration at work can be vital for reframing narrative thoughts about oneself into self-compassionate ones. Furthermore, it has provided me with a passion for ensuring team dynamics and team cohesion are prioritised, as colleagues are likely the first point of contact for support within a team.

Finally, as a staff wellbeing psychologist I am now one of the individuals responsible for developing and delivering training to healthcare staff around wellbeing. My approach to these has been greatly shifted by the results of my thesis; I am constantly cognisant that a poorly considered session may be considered at best glib and unhelpful, or at worst individualising of wellbeing difficulties. It has instilled compassion in me for those who design organisational wellbeing initiatives. I am now acutely aware of the urgent need to give staff something concrete and useful despite having limited resources. My research has meant I now integrate messages about the importance of systemic factors on wellbeing at work, but there is a delicate line between a message of "this is not your fault, things are difficult in the NHS right now" and creating a sense of hopelessness. Ultimately, it again underscores my conclusion that one of the most essential interventions required at present is increased NHS funding, which can provide the resources and working conditions to retain staff.

Conclusion

Although I developed this research with an understanding that I would be writing as an insider researcher, I was ultimately surprised at how closely it began to mirror my experiences as a professional. It has greatly informed my understanding of my own wellbeing and my practice as a clinician and a colleague. As I embark on my qualified career, I also hope to retain these lessons as my career progresses and I begin to supervise other therapists and possibly enter management in the future.

Finally, in addition to developing my skills are a researcher, I developed an appreciation of the intricacies between the work of NHS psychological therapists and the political world. Although this project began in response to the pandemic, it developed organically as it integrated the experiences in wider society. For example, NHS strike action began around the time I commenced data collection. Although I did not expect to capture the impact of salary disputes when writing my proposal, this reflect the real-world importance of this research. I am hopeful that this research can contribute towards meaningful change for my colleagues within the NHS and support the improvement of their working conditions.

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Appendix 1

# ▲	Searches	Results	Type	Actions	Annotations
1	(psychologist* or psychotherapist* or therapist* or mental health practitioner* or mental health professional* or psychological wellbeing practitioner* or high-intensity therap*).ab,id,ti.	212711	Advanced	Display Results More	
2	limit 1 to yr="2013 -Current"	62942	Advanced	Display Results More	
3	(burnout or burn* out or occupational stress or emotional exhaustion).ab,id,ti.	22300	Advanced	Display Results More	
4	limit 3 to yr="2013 -Current"	12506	Advanced	Display Results More	
5	(Work* or organi?ation* or caseload or supervis* or administrative support or peer support or colleague support or training or debrief* or service* or employ* or reflective practice or mental health AJD4 prof* or mental health AJD4 practition*).ab,id,ti.	1646491	Advanced	Display Results More	
6	limit 5 to yr="2013 -Current"	698893	Advanced	Display Results More	
7	2 and 4 and 6	791	Advanced	Display Results More	

Save Remove Combine with: AND OR Contract

Appendix 2

	Qualitative				
	1.1. Is the qualitative approach appropriate to answer the research question?	1.2. Are the qualitative data collection methods adequate to address the research question?	1.3. Are the findings adequately derived from the data?	1.4. Is the interpretation of results sufficiently substantiated by data?	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?
Chang (2014)	Y	Y	Y	Y	Y
Sim et al. (2016)	Y	C	Y	Y	Y
	Quantitative Descriptive				
	4.1. Is the sampling strategy relevant to address the research question?	4.2. Is the sample representative of the target population?	4.3. Are the measurements appropriate?	4.4. Is the risk of nonresponse bias low?	4.5. Is the statistical analysis appropriate to answer the research question?
Allwood et al. (2022)	Y	Y	Y	N	Y
Berjot et al. (2017)	Y	C	Y	N	Y
Boccio et al. (2016)	Y	C	Y	N	Y
Di Benedetto & Swadling (2014)	Y	C	Y	N	Y
Johnson et al. (2020)	Y	C	Y	N	Y

Kotera et al. (2021)	Y	N	C	N	Y
Schilling et al. (2023)	Y	N	Y	N	Y
Serrão et al. (2022)	Y	C	Y	N	Y
Sodeke-Gregson et al. (2013)	Y	C	Y	N	Y
Spännargård et al. (2022)	Y	C	C	N	Y
Steel et al. (2015)	Y	C	C	N	Y
Steel et al. (2015)	Y	N	Y	N	Y

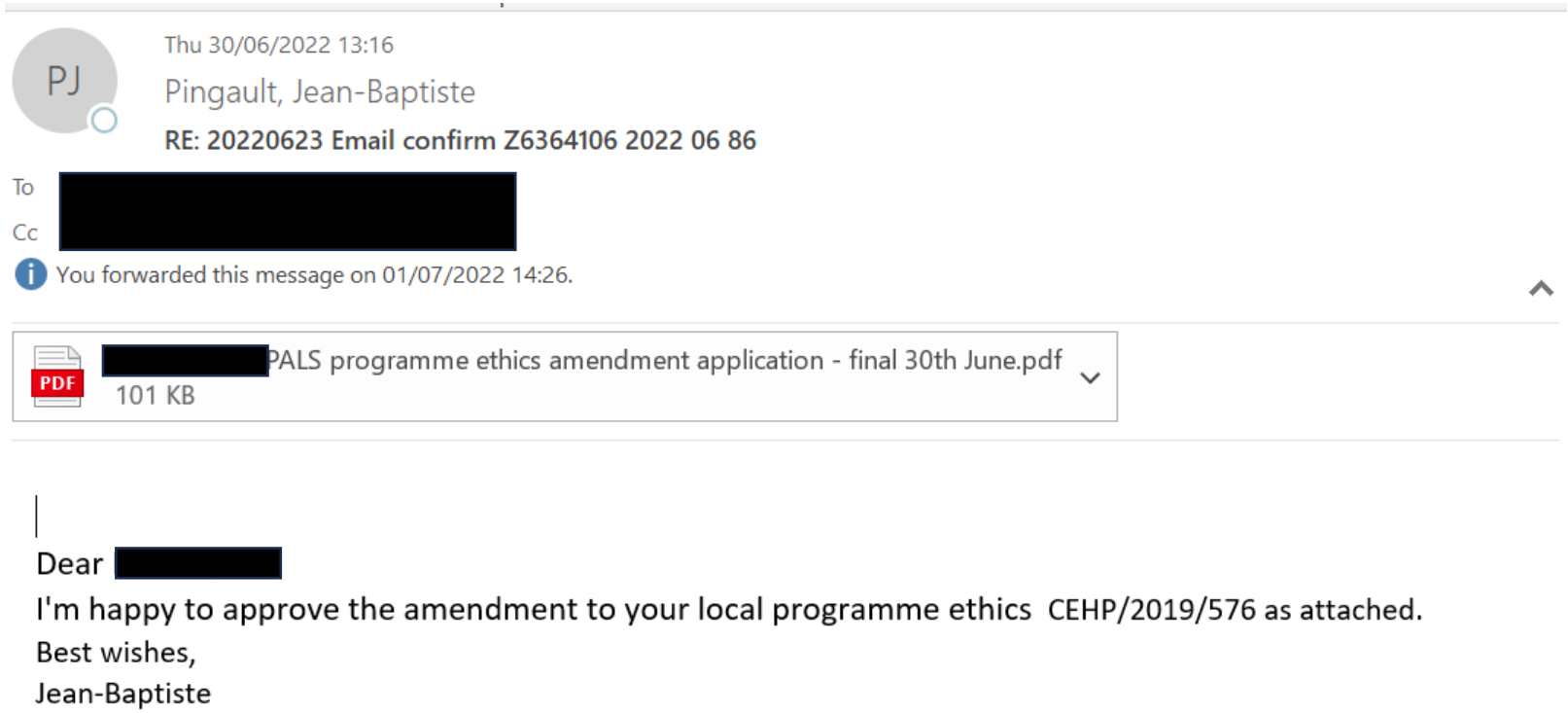
	Mixed Methods				
	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	5.2. Are the different components of the study effectively integrated to answer the research question?	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?
Roncalli & Byrne (2016)	Y	Y	Y	Y	C

Abbreviations: Y – Yes; N – No; C – Can't tell

Appendix 3


We send the EU £350 million a week
let's fund our NHS instead
Vote Leave
Let's take back control
#TakeControl
GETTY IMAGES

Appendix 4



Thu 30/06/2022 13:16

Pingault, Jean-Baptiste

RE: 20220623 Email confirm Z6364106 2022 06 86

To [redacted]

Cc

You forwarded this message on 01/07/2022 14:26.

PDF [redacted]PALS programme ethics amendment application - final 30th June.pdf

101 KB

Dear [redacted]

I'm happy to approve the amendment to your local programme ethics CEHP/2019/576 as attached.

Best wishes,

Jean-Baptiste

Appendix 5

Participant Information Sheet For Psychological Therapists

UCL Research Ethics Committee Approval ID Number: CEHP/2019/576

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: A qualitative exploration of the mental health and wellbeing of psychological therapists
Department: Clinical, Educational and Health Psychology (CEHP)
Name and Contact Details of the Researcher(s): REDACTED
Name and Contact Details of the Principal Researcher: Prof. Katrina Scior
REDACTED

Invitation Paragraph

You are being invited to take part in a research project. Before you decide whether to take part it is important for you to understand why the research is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part. Thank you for reading this.

What is the project's purpose?

There is scarce research around the impact that supporting others through distress and difficult life experiences has on the wellbeing of psychological therapists themselves. So far, the literature indicates that there are ways working as a psychological therapist can both enhance one's wellbeing, but also how it can negatively impact it. We are hoping to understand therapist opinions about how they feel their work impacts their mental health and wellbeing. We are also interested in what strategies or support systems they use to manage their wellbeing, and any barriers to accessing these. Finally, given the changes to personal and professional lives that have occurred over the previous two years of the pandemic, we will ask about your experience of working and managing your wellbeing at this time.

Why have I been chosen?

You have been invited to take part in this study as you are a UK-based psychological therapist (e.g. clinical psychologists, PWPs, CBT therapists, psychotherapists). A psychological therapist is defined as a mental healthcare professional who is delivering evidence-based psychological therapeutic interventions as a major part of your role. Only qualified staff are eligible to be part of this study. We are interested in your view on your own wellbeing and mental health and management, including how the experience of working through the COVID-19 pandemic has impacted them.

Do I have to take part?

Taking part in this study is entirely voluntary. If you do decide to take part, you will be asked to electronically sign a consent form and return it to the researcher. You can withdraw your consent to take part up to **two weeks** after the interview, after which point your data will have been anonymised and included in the analysis and it will not be possible to retract the information

What will happen to me if I take part?

You will be invited to take part in a one-off interview, lasting up to an hour. The interview will take place at a time convenient to you and will be remotely using Zoom/MS Teams or face-to-face at UCL, depending on your preference. The interviews will be recorded and subsequently transcribed by the interviewer. No identifying details of you or your place of work will be included in the transcripts. Once transcribed and checked, the original recording will be deleted.

What do I have to do?

If you decide you would like to take part in this study, please contact the lead researcher, **REDACTED**, at **REDACTED**. You will be sent a consent form and sociodemographic form to complete and return electronically. We will then arrange a convenient time for you to take part in the interview.

What are the possible disadvantages and risks of taking part?

You will be asked about your view about how your own wellbeing and mental health are impacted, both positively and negatively, by your work as a psychological therapist. We will also ask about you attitudes towards managing your wellbeing, and any strategies or systems you use. We will also ask about how your mental health and wellbeing as a psychological therapist have been impacted by the experience of working during the COVID-19 pandemic. Some of your experiences may have been difficult and talking about this could be distressing. You will be able to take breaks if needed and can pause and continue the interview at another time if preferred. You do not have to answer any questions if you do not wish to. Should you continue to feel distressed then the researcher will be able to signpost you to relevant sources of support.

Where can I get help if I become distressed?

Should you become aware of experiencing psychological distress at any point during the research process you can:

- Speak to your supervisor or line manager if you need additional support at work
- Call the National **NHS Helpline** on **0300 131 7000**
- For support via text messages, text **FRONTLINE** to **85258**
- Contact your GP for support and to access local Psychological Therapy Services.

What are the possible benefits of taking part?

Whilst there are no immediate and personal benefits for the people participating in the project, it is hoped that this work will inform future guidance about how best to support psychological therapists.

What if something goes wrong?

If you are unhappy with any aspect of the research process then please do contact the Principal Investigator, who is overseeing this research, Prof. Katrina Scior at **REDACTED**. If Prof. Scior is not able to handle your complaint to your satisfaction then you would be able to contact the UCL Research Ethics Chair at ethics@ucl.ac.uk.

In the unlikely event that during your interview concerns were raised about a serious adverse event, then it may be necessary for us to contact your professional body, but this would be discussed in full with you.

Will my taking part in this project be kept confidential?

Any information that we collect about you will be kept strictly confidential. Your contact details will be used solely for the purposes of sharing information about the study, obtaining consent and arranging a time for the interview. Once the interview is completed, this information will be deleted.

During the interview you will be reminded not to mention any identifying details of your colleagues or place of work. If any potentially identifying information is mentioned, this will not be included in the transcript of the interview. After your interview has been transcribed, the original recording will be deleted and the transcript will be saved under a pseudonym. You will not be able to be identified in any ensuing reports or publication.

What will happen to the results of the research project?

The findings of the study will be written up in more detail for dissemination in a peer-reviewed journal. Only the researcher team involved in this project will have access to your data. The pseudonymized data will be archived by UCL and kept for 10 years, in line with UCL policy. This data may be accessed at some point in the future, but only with the permission and under the supervision of the Principal Investigator, Prof. Katrina Scior.

Local Data Protection Privacy Notice

Notice:
The controller for this project will be University College London (UCL). The UCL Data Protection Officer, Alex Potts, provides oversight of UCL activities involving the processing of personal data, and can be contacted at **REDACTED**.

This ‘local’ privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our ‘general’ privacy notice:

For participants in health and care research studies, click here

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The lawful basis that will be used to process your personal data are: 'Public task' for personal data, and 'research purposes' will be the lawful basis for processing special category data.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

Who is organising and funding the research?

There is no external funding or sponsorship of this research. The research project is conducted as part of the Doctorate in Clinical Psychology at UCL.

Contact for further information:

If you have any questions about any aspect of the research process you can contact the Lead Researcher, **REDACTED**. If you have any questions about data protection, please contact the data protection officer Alex Potts at **REDACTED**

Thank you for reading this information sheet and for considering to take part in this research study.

Appendix 6

CONSENT FORM FOR PSYCHOLOGICAL THERAPISTS IN RESEARCH STUDIES

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: A qualitative exploration of the mental health and wellbeing of psychological therapists in the context of the COVID-19 pandemic
Department: Clinical, Educational and Health Psychology
Name and Contact Details of the Researcher(s): REDACTED
Name and Contact Details of the Principal Researcher: Prof. Katrina Scior REDACTED
Name and Contact Details of the UCL Data Protection Officer: Alexandra Potts data-protection@ucl.ac.uk
This study has been approved by the UCL Research Ethics Committee: CEHP/2019/576

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking/initialling each box below I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

		Initial Here
	I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction. I agree to take part in an individual interview.	
	I understand that I will be able to withdraw my data up until two weeks after the interview.	
	I consent to the processing of my personal information about my personal wellbeing and mental health professional role, and personal experience of how the COVID-19 pandemic has impacted them for the purposes explained to me. I understand that according to data protection legislation, 'public task' will be the lawful basis for processing, and 'research purposes' will be the lawful basis for processing special category data.	
	I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified I understand that my data gathered in this study will be stored anonymously and securely. It will not be possible to identify me in any publications.	

	I understand that my information may be subject to review by responsible individuals from UCL for monitoring and audit purposes.	
	I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. I understand that if I decide to withdraw, any personal data I have provided up to that point will be deleted unless I agree otherwise.	
	I understand the potential risks of participating and the support that will be available to me should I become distressed during the research interview.	
	I understand there is no direct personal benefits of participating.	
	I understand that the data will not be made available to any commercial organisations but is solely the responsibility of the researcher(s) undertaking this study.	
	I understand that I will not benefit financially from this study or from any possible outcome it may result in in the future.	
	I agree that my anonymised research data may be used by others for future research. [No one will be able to identify you when this data is shared.]	
	I understand that the information I have submitted will be published as a report and I wish to receive a copy of it. Yes/No	
	I consent to my interview being audio/video recorded and understand that the audio recordings will be destroyed immediately following transcription. Interview transcripts will be stored anonymously, using password-protected software and will be used for training, quality control, audit and specific research purposes.	
	I hereby confirm that I understand the inclusion criteria as detailed in the Information Sheet and explained to me by the researcher.	
	I have informed the researcher of any other research in which I am currently involved or have been involved in during the past 12 months.	
	I am aware of who I should contact if I wish to lodge a complaint.	
	I voluntarily agree to take part in this study.	
	I would be happy for the data I provide to be archived by UCL and kept for 10 years, in line with UCL policy. This data may be accessed at some point in the future, but only with the permission and under the supervision of the Principal Investigator, Prof. Katrina Scior. I understand that other authenticated researchers will have access to my anonymised data.	

If you would like your contact details to be retained so that you can be contacted in the future by UCL researchers who would like to invite you to participate in follow up studies to this project, or in future studies of a similar nature, please tick the appropriate box below.

	Yes, I would be happy to be contacted in this way	
	No, I would not like to be contacted	

Name of participant Date Signature

Appendix 7

Sociodemographic Form

Please state your age group:

☐ 18-25
☐ 26-35
☐ 36-45
☐ 46-55
☐ 56+
☐ Prefer not to say

Please state your gender:

☐ Female
☐ Male
☐ Non-binary
☐ Prefer not to say

Please state your ethnic group:

☐ Asian or British Asian
☐ Black African, Black British, or Caribbean
☐ Mixed or multiple ethnic groups
☐ White British, White European, or White – other
☐ Another ethnic group
☐ Prefer not to say

Please state which region you work in:

☐ England – South East
☐ England – London
☐ England – South Central
☐ England – South West
☐ England – Midlands
☐ England – North East
☐ England – North West
☐ Scotland – Highlands and Islands

☐ Scotland – Central, Fife and Northeast
☐ Scotland – Glasgow, Edinburgh and Lothians
☐ Scotland – Ayrshire and South
☐ Wales – South Wales
☐ Wales – West Wales
☐ Wales – Mid Wales
☐ Wales – North Wales

Please state your professional group:

☐ Clinical psychologist
☐ Cognitive-behavioural therapist
☐ Counselling psychologist
☐ Mental health occupational therapist
☐ Psychiatrist
☐ Psychodynamic psychotherapist
☐ Psychological wellbeing practitioner
☐ Other (please specify): _____

Please state which setting you work in:

☐ Primary care (including IAPT)
☐ Secondary care
☐ Mental health hospital setting
☐ General/acute medical hospital setting
☐ Older adult hospital setting
☐ Older adult community setting
☐ CAMHS hospital setting
☐ CAMHS community setting
☐ Learning disability service
☐ Forensic service

Appendix 8

Interview Schedule: Psychological Therapists and Wellbeing

Thank you for agreeing to be interviewed for this study. The interview should last about 45 minutes to an hour. If you need to take a break at any point, please let me know and we can pause. In case you change your mind about participating during or after the interview, please let me know. In case you change your mind after the interview, I ask that you let me know within two weeks and your information will be removed.
I have a set list of questions I will be asking you, but if you feel uncomfortable answering any please let me know and we can skip them. I will be asking some questions about your current role and the impact your work has had on your wellbeing. These questions will be about your qualified career so far as a whole. I would like to record the interview and will transcribe it afterwards. Please avoid mentioning anything that could identify yourself, your workplace or your colleagues to keep your and others' identity anonymous. However, if you do accidentally mention something that might make you or someone else identifiable, I will remove it when I transcribe the interview. Do you have any questions or are you happy to continue? Are you happy for me to record the interview? Thank you.

1. To begin, could you tell me about your role?

- *What type of service?*
- *What does your role involve?*
- *How long have you been there?*

2. Could you tell me about the ways you feel your work itself impacts your mental health and wellbeing?

Enhances

- *Are there ways your work has positively impacted your mental health and wellbeing?*
- *What about your work makes you feel good?*

Diminishes

- *Are there ways your work has negatively impacted your mental health and wellbeing?*
- *Are these effects short-term or longer-term? (e.g. bad mood, stressful days versus burnout, difficulties with mental health, chronic stress)*
- *Would you say this effect on your wellbeing has been mostly psychological or has it affected you physically as well?*

3. Could you tell me some things you personally find helpful in looking after your wellbeing?

- What are the main sources of support you find most helpful within the workplace? (supervisor/management/colleagues/breaks)
- Are there any systems of support in your Trust or department which you find particularly helpful?
- What types of things do you do regularly (daily/weekly) to maintain your wellbeing, either during the workday or outside it?

4. Thinking of [the things/people you found most helpful], could you tell me how able you feel to get support using [the things/people]?

- Can you tell me how often you use [the thing/people] when you feel you are struggling at work?
*- What are the barriers to being able to utilise this? [Personally, e.g. shame, or practically, e.g. time, remote work)**
- Do you feel like support is offered proactively, or do you feel the responsibility on you to seek it out?
- Do you feel the support you get is enough?

5. Could you please tell me about where you worked during the pandemic and your experience of working as a therapist then?

- *Were you working in your current job?*
- *Were you working remotely or in person?*
- *Did the work involved in your role change?*

6. How did the pandemic impact the relationship between your wellbeing and your work?

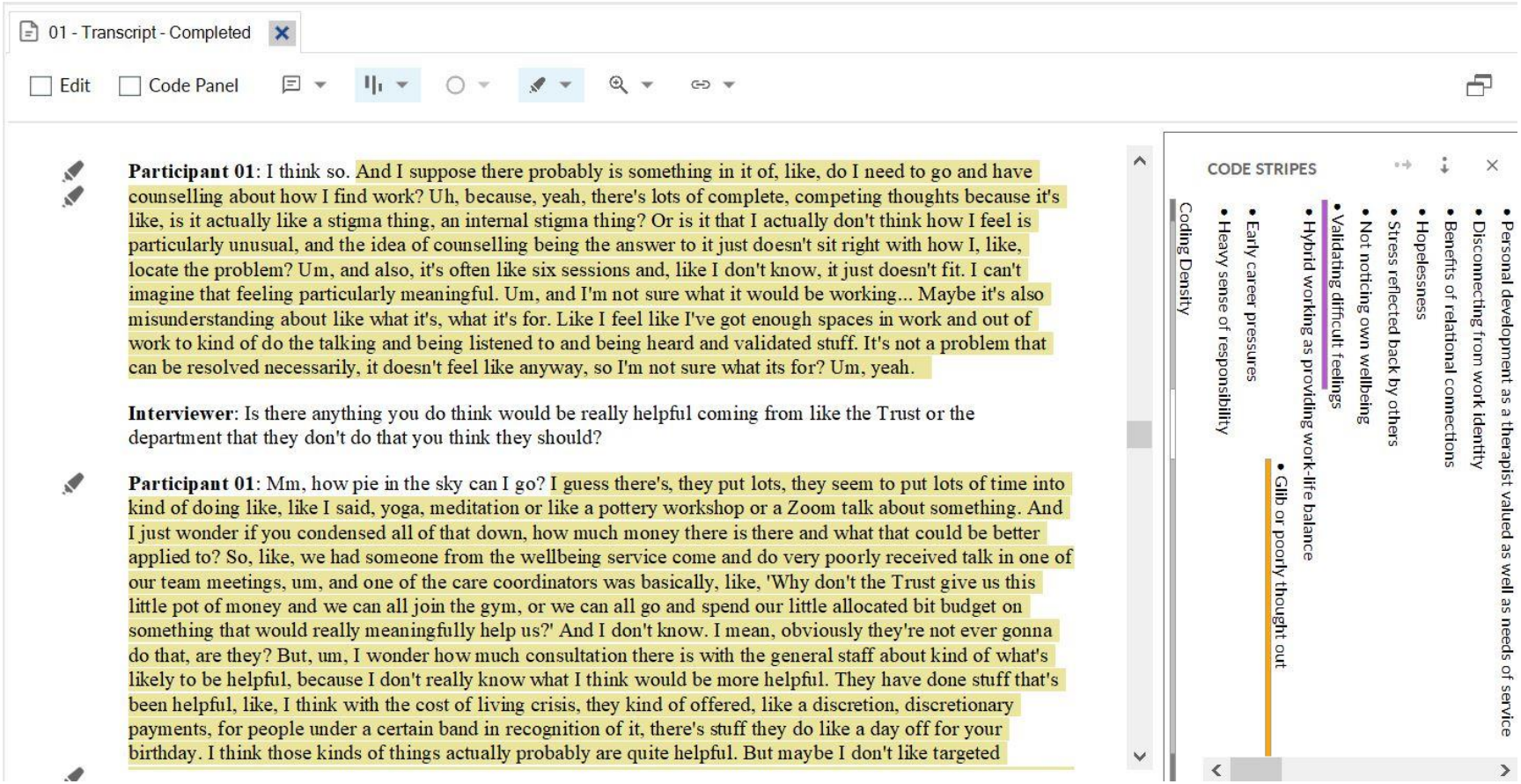
- *Did you feel properly supported?*
- *Did sources of support change?*
- *Did you find it easier or more difficult to access support than pre-pandemic?*
- *How were things during the first lockdown?*
- *How was this after restrictions began to lift last year?*
- *How were things during the winter lockdown at the end of 2020?*
- *How do things feel now?*
- *Thinking about the impact of the pandemic on you personally, did this affect your relationship with your job?*

7. What, if any, changes do you think should be made to your role to enable you to maintain your wellbeing?

- *What about support offered in your workplace and/or existing structures?*
- *Is there anything you think could be introduced or conversely stopped which would be beneficial to your wellbeing?*

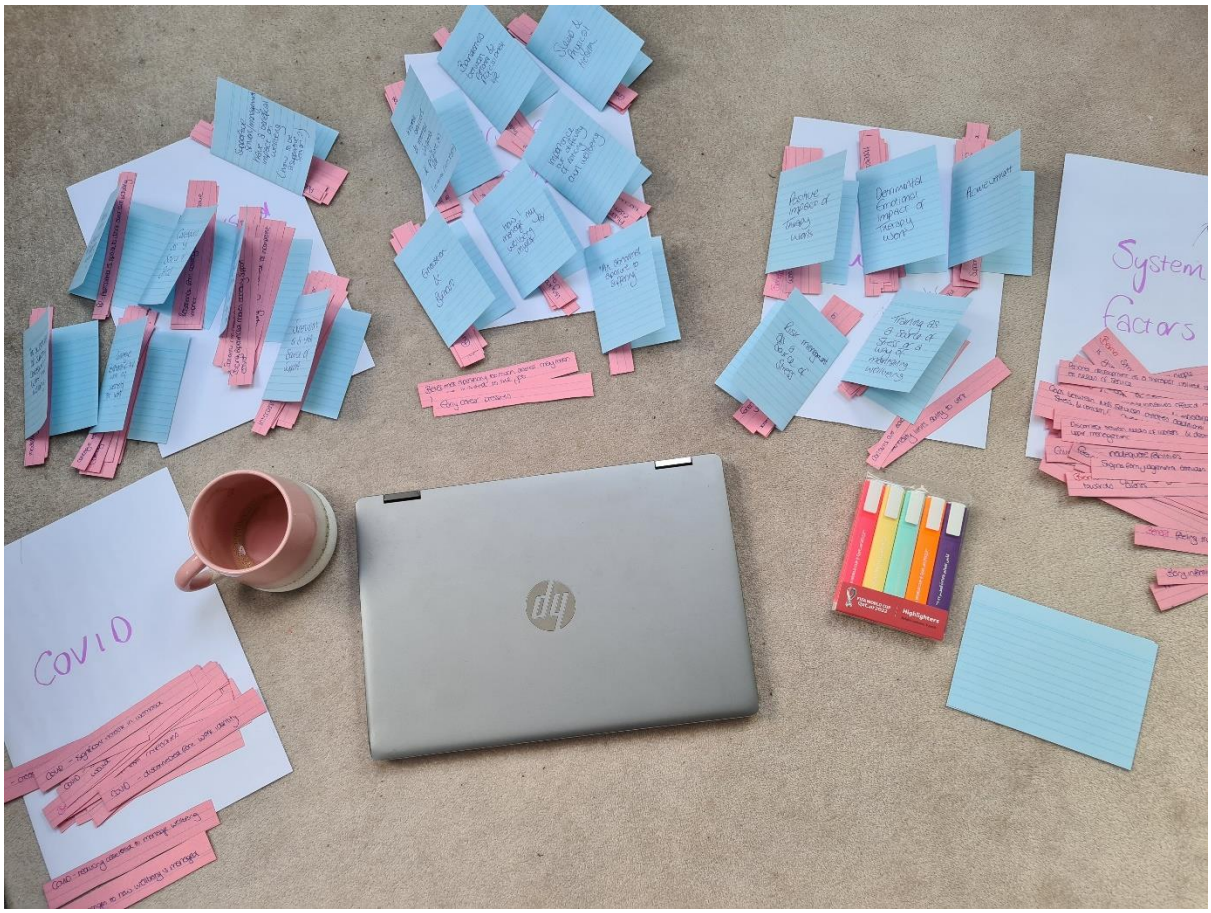
8. That is the end of my questions. Is there anything else you would like to add which you feel we haven't covered yet?

Appendix 9



Extract from interview with NVivo coding stripes on right hand side, and coding sections highlighted in yellow

Appendix 10



Codes (pink) grouped by organising domains (A4 paper) and collapsed codes (blue)

Appendix 11

Organisational Domains	Collapsed codes	THEMES
Interpersonal Support	Colleague relationships help with my wellbeing at work	How colleagues enhance or inhibit wellbeing
	An awareness of supporting colleagues with their wellbeing	
	Colleagues as a source of stress	
	Interpersonal barriers to wellbeing or accessing support	
	Supervision is a vital source of support	Formal support within teams
	Reflective practice is a helpful space for supporting wellbeing	
	How seniors and managers can support wellbeing	The importance of supportive management
Personal Factors	Internal stigma, barriers and pressure	Over-achieving, stigma and shame
	How I manage my wellbeing for myself	Strategies for maintaining individual wellbeing
	Boundaries between personal and professional life	
	Sleep and physical health	Physical and psychological indicators of work-related stress
	Exhaustion and burnout	
	Importance but difficulty of noticing own wellbeing	
Impact of Work as a Therapist	Positive impact of therapy work	Meaning, purpose and achievement
	Achievement	
	Detrimental emotional impact of therapy work	Holding distress and risk
	Risk management as a source of stress	
	Training as a source of stress or way of maintaining wellbeing	The double-edged sword of training
Systemic Factors	Politics and austerity	The impact of austerity
	Issues in NHS system which impact wellbeing of worker	
	Environment and facilities	
	Undermining, constraining or invalidating organisational culture	Facets of a supportive organisational culture
	Psychologically safe organisational culture	
	Stress within teams	Wellbeing at the team and Trust level
	Trust wellbeing initiatives not seen as useful	
Consequences of the COVID-19 pandemic	How the pandemic impacted wellbeing at work	How the pandemic impacted work-related wellbeing
	Managing wellbeing during the pandemic	
	The relationship between remote working and wellbeing	The introduction of remote working and its consequences

Organising domains, with collapsed codes organised by domains, and how these were grouped to themes.