SCHOOL OF PSYCHOLOGY

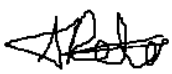
DOCTORATE IN CLINICAL PSYCHOLOGY

MAJOR RESEARCH PROJECT

Well-being and Burnout in Psychologists

Submitted by Amy Claire Peters to the University of Exeter as a thesis for the degree of Doctor of Clinical Psychology, March 2023.

I certify that all material in this thesis, which is not my work, has been identified and that any material that has previously been submitted and approved for the award of a degree by this or any other University has been acknowledged.

Signed: 

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Systematic Literature Review

Burnout in Qualified Psychologists: A Systematic Review of the Prevalence, Causes and Associated Factors.

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Abstract

Objective: Burnout among healthcare professionals is an increasing concern due to adverse outcomes for clinicians, clients, and organisations (Bridgeman et al., 2018; Azoulay et al., 2020). One identified systematic review (McCormack et al., 2018) has explored burnout in psychologists and psychological therapists; however, no identified reviews have focused solely on psychologists. This review aimed to investigate the prevalence, causes and factors associated with burnout in psychologists.

Method: Studies related to burnout in psychologists, published before September 2021, were obtained from multidisciplinary databases. The search yielded 582 papers, 26 papers were eligible for review. Researchers conducted a thematic synthesis (Nicholson et al., 2016). Final themes were developed by identifying commonalities across the sub-themes from separately grouped qualitative and quantitative studies.

Findings: Psychologists experienced moderate to high levels of burnout related to emotional exhaustion. Narrative synthesis highlighted three themes concerning burnout-related factors: age and gender, occupational experiences such as job demands, and personal resources such as humour and beliefs about burnout. The development of support networks was found to be an important protective factor for the included psychologists.

Conclusions: Emotional Exhaustion (EE) may play a key role in psychologists' experiences of burnout, and further research relating to the experiences of EE in younger and recently qualified psychologists may help to inform prevention and intervention strategies.

Keywords: *psychologists, burnout, emotional exhaustion, systematic review.*

Introduction

Like many healthcare practitioners, psychologists may experience burnout during their careers (Turnbull & Rhodes, 2021). The increasing concern regarding burnout in healthcare populations is rooted in adverse personal and occupational outcomes (Bridgeman et al., 2018). Burnout can lead to poor mental health in healthcare workers (Morse et al., 2012); however, its impact is not limited to the individual. Poor patient outcomes (Hall et al., 2016) and interpersonal difficulties with colleagues (Guidroz et al., 2012; Vincent et al., 2019) have also been associated with burnout. Burnout significantly contributes to the absenteeism, retention, and recruitment costs healthcare providers face (Kirby., 2023).

Psychologists comprise the most significant proportion of the NHS psychological professions workforce at over 40% (HEE., 2021). The Mental Health Implementation Plan proposed ambitious plans to recruit 2,520 additional psychologists into the workforce by 2024 (HEE., 2021) to meet the demand for psychological interventions in the NHS (Iqbal et al., 2021). Despite this, burnout in UK-based psychologists is under-researched. Understanding psychologists' burnout experiences is imperative to supporting psychologists, teams, clients and the ongoing expansion of the psychological workforce.

This review synthesised international literature relating to burnout in psychologists. The conceptualisation and measurement of burnout are briefly explored alongside research concerning burnout among psychologists.

Burnout

Burnout was introduced in 1975 as a work-related stress condition in healthcare volunteers, resulting from long-term exposure to work-related stress (Freudenberger, 1975). Maslach and colleagues later described burnout as a state precipitated by a prolonged period of chronic emotional and interpersonal workplace stressors (Maslach et al., 2001). Burnout is characterised by three dimensions; exhaustion, cynicism, and inefficiency (Maslach et al., 2001). Exhaustion represents the depletion of emotional and physical resources. Cynicism, or depersonalisation, reflects the individual's negative or critical responses towards their job, clients and colleagues, whilst reduced efficiency refers to feelings of incompetence or lack of personal achievement.

Maslach's (1982) model of burnout led to the development of the Maslach Burnout Inventory (MBI; Maslach et al., 1997), a 22-item self-report tool designed to measure the presence of the three dimensions of burnout. The MBI is well-validated and has been adapted to several other languages and populations (Pisanti et al., 2013; Dolan et al., 2015). Despite being considered the gold standard in burnout measurement (Williamson et al., 2018), the MBI is not the only measure used in research. The MBI is based on Maslach's three dimensions; however, other proposed dimensions can be used to measure prevalence. The Copenhagen Burnout Inventory (CBI) (Kristensen et al., 2005), for example, identifies the presence of burnout by using three different dimensions of burnout: personal, work-related, and client-related. Edú-Valsania and colleagues (2022) provide a comprehensive review of burnout measurement that is out of the scope of this review. It is, however, essential to acknowledge that researchers' choice of burnout tools is crucial. It significantly

impacts how burnout is conceptualised, the aspects of experience being measured, and the potential interpretation and impact on proposed interventions.

Burnout in Psychologists

Psychologists are at a high risk of work-related emotional distress and burnout (Kumary & Baker, 2008; Emery et al., 2009; Di Benedetto & Swadling, 2014). This is partly due to the intensity of the emotional experiences that constitute their daily working life, including witnessing distress, trauma, and loss (Rabu et al., 2016; Wise & Barnett., 2016). High caseloads, long waiting lists, and high levels of autonomy have all been identified as additional work-related stressors for psychologists (Johnson et al., 2012; McCormack et al., 2018). Though these differ cross-culturally, long wait times (Kowalewski et al., 2011; Olver et al., 2011; Ofonedu, et al.,2017; Punton et al., 2022), difficulties with recruitment and retention (Fukui, & Salyers., 2019; Cosgrave., 2020), and increasing demand are challenges faced by psychologists internationally. The accumulation of these challenges can contribute to the experience of burnout.

Burnout is associated with significant adverse outcomes. Evidence suggests that burnout can negatively impact quality of life and is positively correlated with anxiety and depression (Morse et al., 2012), suicidal ideation (Dyrbye et al., 2008), and emotion dysregulation (Gorgievski & Hobfoll, 2008; Toh et al., 2012). Burnout poses a severe threat to healthcare providers as burnout can 'transfer' between colleagues (Westman & Bakker., 2008 pp 1), leading to poorer outcomes for patients (Hall et al., 2016) and increased levels

of clinical errors (Wilkinson et al., 2017). At an organisational level, burnout is associated with increased absenteeism (Johnson et al., 2018), occupational disengagement (Millar., 2018) and job withdrawal (Sheather & Slatter., 2021). Lastly, the increased levels of staff sickness related to burnout (Summers et al., 2021) and the subsequent impact on the retention and recruitment of staff contribute to the growing financial crisis related to the retention and recruitment of NHS staff, such as psychologists (Kirby., 2023).

Not only are psychologists expected to manage the pressures and demands described, but unlike many other healthcare professions, they are also expected to provide interventions to support the well-being of their teams and reduce burnout (Heneghan et al., 2014; BPS., 2017). In addition, psychologists hold leadership and management responsibilities alongside their clinical workload (Channer et al., 2018). Though this varies, this is often not the case for the healthcare workers with whom psychologists are grouped within the research, e.g., mental health practitioners. There is also evidence that psychologists may experience mental health stigma related to a perceived expectation to know how to cope, which could negatively impact support-seeking (Tay et al., 2018). The research does not provide insight into the specific impacts of these factors concerning burnout; however, it is reasonable to suggest that these additional demands mean that psychologists' experience of burnout may differ somewhat from their healthcare colleagues. As such, the experiences of psychologists must be considered independently of their healthcare colleagues to allow researchers to identify specific experiences and needs of the population.

Review Rationale

Burnout in psychologists is a complex issue that can be impactful at individual, service, and organisational levels. To the researcher's knowledge, only one systematic review, that of McCormack and colleagues (2018), has explored burnout in psychologists capturing data published before 31st December 2016. The proposed review may capture research published between 2016 and 2022, thus providing a beneficial updated picture in relation to the prevalence factors and causes of burnout in psychologists. An updated review would also capture the influx in research around burnout resulting from the impact of the Covid-19 pandemic on healthcare workers (Gonda & Tarazi., 2022). In addition, although McCormack et al. (2018) did capture burnout in psychologists, they also included allied mental health practitioners in their population samples (McCormack et al., 2018). Thus the population sample is relatively broad. By narrowing the inclusion criteria, this review can draw conclusions specifically relating to the experience of psychologists who may have different burnout experiences and needs compared to their multi-disciplinary colleagues. As such, recommendations can be tailored specifically to the needs of psychologists.

To the researcher's knowledge, there do not appear to have been any attempts to explore the research relating specifically to professional psychologists, including data published between 2016 and 2022. For transparency, the researcher broadened the search for existing literature reviews to cover any published reviews exploring burnout-related concepts, such as compassion fatigue and emotional exhaustion. Though the search did yield a systematic review exploring compassion fatigue in healthcare workers

(Cavanagh et al., 2020), the population here included a broad range of healthcare workers, with only two of the seventy-one included papers including psychologists in their sample. A search of the Cochrane Databases yielded no registered reviews intending to collate the proposed review question.

Review Aims and Objectives

The current paper aims to systematically review international research regarding the causes and prevalence of burnout among psychologists. Examining the existing research may support researchers and clinicians to better understand the development process and potentially nuanced experiences of psychologists. Thus, potentially leading to more appropriately informed prevention and intervention strategies. This systematic review aims to answer the following questions:

1. What is the prevalence of burnout among psychologists?
2. What are the causes and factors related to burnout in psychologists?

Method

Design

This paper describes a mixed-methods systematic literature review. The Joanna Briggs Institute Clinical Appraisal Tools (JBI) (Joanna Briggs Institute, 2017) were selected to appraise the included studies' methodological rigour and highlight potential areas of caution when interpreting the findings. A narrative, thematic synthesis (TS) was used to analyse the identified studies to enable the researchers to move beyond the original study findings and generate related themes across the data (Thomas & Harden, 2008).

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Page et al., 2021) guidance was used to ensure the review was of sound quality and could be easily replicated (Appendix A).

Screening and Sampling

The SPIDER framework (Cooke et al., 2012) was adapted to support the development of inclusion criteria and search terms.

Inclusion / Exclusion Criteria

An independent qualitative researcher and health psychologist consulted with the researchers during the development of the inclusion criteria presented in Table 1. Both quantitative and qualitative empirical papers were included. Grey literature and papers not published in English were excluded. Though peer review has not always ensured validity (Smith., 2006), grey literature was excluded to support the review's rigour. Papers with samples of school psychologists (SPs) were excluded to preserve the homogeneity of the sample, as the SPs' training pathway and responsibilities differ significantly from other registered psychologists (NASP, 2022). Papers focusing on interventions were excluded as they fell outside the review scope.

Table 1

Inclusion and Exclusion Criteria

SPIDER	Inclusion	Exclusion
Sample	Participants were trainee or qualified psychologists from one of six disciplines: clinical, health,	School Psychologists Pre-qualification psychologists

	counselling, forensic, education or sport.	
Phenomena of Interest	One or more dimensions of burnout as defined by the burnout tool utilised in the study.	
Design	Qualitative, Quantitative and Mixed Methods research reporting on primary data	
Evaluation	Prevalence of burnout in the sample Causal Factors relating to the development or experience of burnout	
Research Type	Qualitative, Quantitative and Mixed Methods	Grey literature
	Studies published in the English language.	Existing literature, or systematic reviews
	Studies published in a peer-reviewed journal.	Publications not reporting primary data

Search Terms

Search terms (STs), provided in Table 2, were developed in three stages:

1. A scoping search was carried out to generate key STs and test the sensitivity and specificity of the search terms developed using SPIDER.
2. These were cross-referenced with the STs used in systematic reviews of burnout in other healthcare professionals (McCormack et al., 2018; O'Connor et al., 2018).

3. Consultation with the University of Exeter Psychology Liaison Librarian to identify any database-specific medical subject headings (MeSH) terms to improve the search strategy.

Terms relating to measurable outcomes were kept broad to reflect the breadth of burnout dimensions. Greater sensitivity and specificity were applied to the population terms. Search terms were applied to MEDLINE, PsychInfo, and Webb of Science; MeSH terms and age filters were used in Medline and PsychInfo only (Appendix B).

Table 2

Search Terms

1	Burnout
2	Psychologist*
3	Stress*
4	Emotional exhaustion
5	Pressure
6	Coping
7	Manage
8	Well-being
9	Mental health
10	Work-related stress
11	Compassion fatigue
12	1 AND 2
13	3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11
14	12 AND 13

Screening Procedure

Duplicate papers were identified using Rayyan Intelligent Systematic Review software, checked manually, and then deleted. Next, titles and abstracts were screened against the inclusion criteria, and those which did not satisfy the requirements were rejected. As recommended by (Boland et al., 2017), the full text of the remaining papers was then read, and papers which satisfied the inclusion criteria were included for review. Lastly, following the National Institute for Health and Care Excellence (NICE) (2012) guidelines for the compilation of systematic reviews, the reference lists of all eligible papers were screened for relevant papers not generated by the search strategy.

Data Extraction

A data extraction table was developed using the SPIDER framework, discussions with the research team, and consideration of information pertinent to the research questions. The table included sample characteristics, country, study design, use of burnout measures, key findings and limitations (Appendix C).

Quality Appraisal

Quality appraisals (QA) in mixed methods reviews can present challenges due to the heterogeneity of the study designs (Hong et al., 2018). The Mixed Methods Assessment Tool (MMAT) (Pluye et al., 2009a, Pace et al., 2012, Hong et al., 2018) was developed specifically for use in mixed methods reviews and was initially selected for this review. After completing QA on three

of the included papers, it became apparent that the MMAT did not capture some of the nuances of qualitative design, such as the researcher's relationship to the data. Additionally, the checklist format of the MMAT did not allow for descriptive notes by the researchers, which was essential to ensure consistency of judgement-making when reviewing a large number of studies. Alternative options were explored, whereby papers could be assessed by tools specific to the research design whilst maintaining some continuity of assessment quality across the tools.

Based on this rationale, papers were assessed using analytical cross-sectional or qualitative JBI Clinical Appraisal Tools (Appendices D and E). The JBI tools use a mix of multiple-choice and open questions to assess the quality and allow for descriptive comments from the assessor (Joanna Briggs Institute, 2017). Mixed-methods studies were appraised twice, once using the appropriate quantitative checklist and then again using the qualitative checklist. One point was awarded for each criterion fully met. Mixed methods papers were awarded two scores. An independent researcher quality assessed six papers. Inter-rater reliability was calculated using Cohen's kappa ($k = 0.83$).

Data Analysis

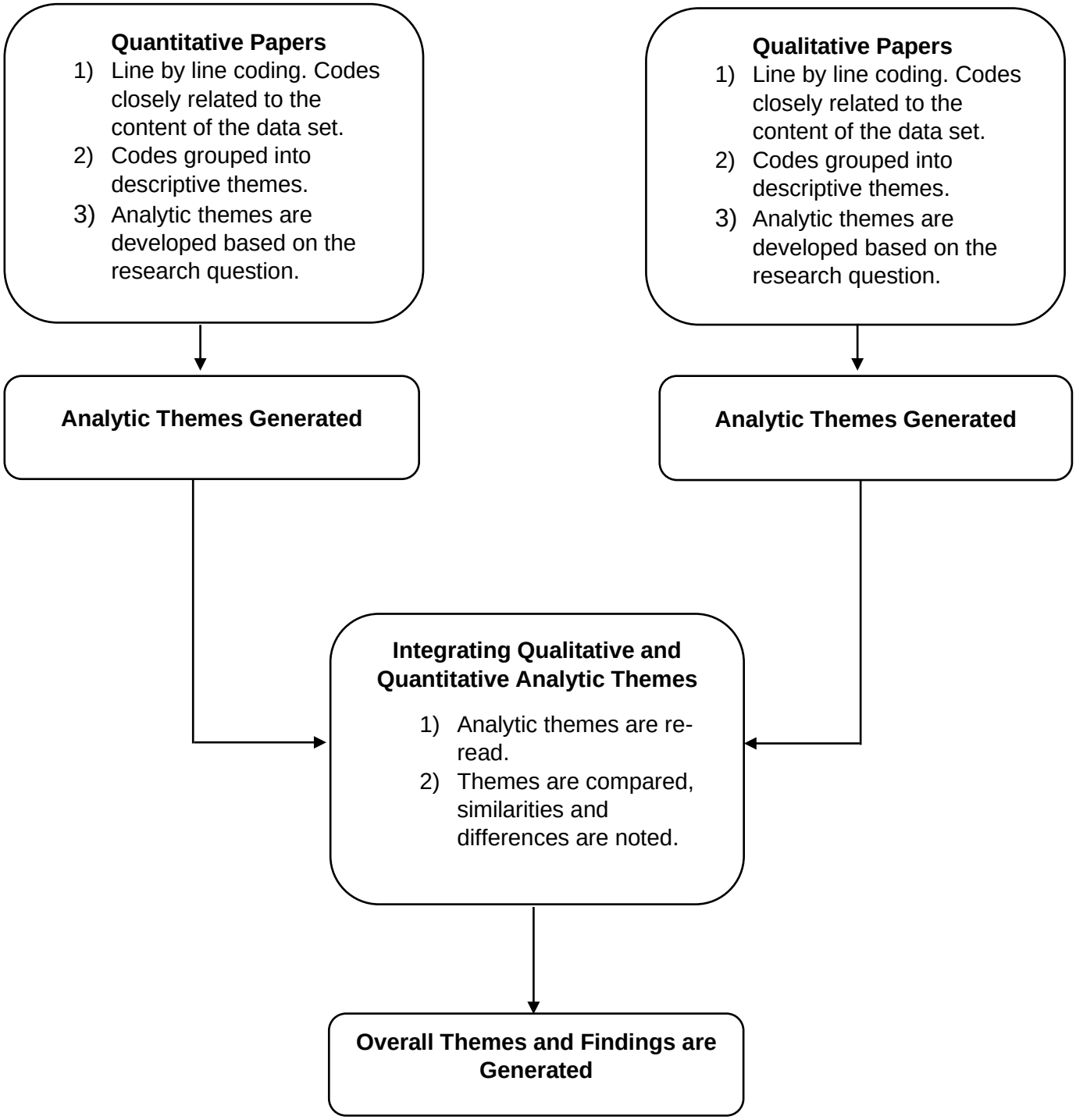
Thomas and Harden's (2008) thematic synthesis guidance was applied to analyse the data and to develop descriptive and analytic themes (Figure 1). TS was selected as it offers consistency across the analysis of qualitative and quantitative data, is well suited to reviewing medium size data sets, and has been successfully applied to mixed methods health-related literature reviews (Dixon-Woods et al., 2005; Nicholson et al., 2016; Etkind et al., 2018; Ryan et

al., 2018). TS also encourages transparency, which is essential for the clarity and quality of findings generated by synthesising data (Tong et al., 2012).

In line with Thomas and Harden's (2008) model, all data labelled *results* or *findings* were extracted from the papers for analysis. The qualitative and quantitative data from the mixed methods paper (#15) were separated and analysed with the respective data. The analysis took place in three stages (each stage applied to the quantitative data first and then to the qualitative data). First, data was line-by-line coded, generating descriptive codes. Next, codes were grouped into descriptive themes based on commonalities or patterns in the data. Finally, to 'go beyond' the primary data (Thomas & Harden., 2008), analytic themes were developed by critically reviewing the descriptive themes in light of the research question. Once this process was completed for both quantitative and qualitative papers, the analytic themes were compared. Similarities and differences were identified, leading to an overall account of the synthesis findings.

Figure 1

Summary of the data analysis process.



Findings

In total, 721 papers were identified in MEDLINE, PsychInfo and Webb of Science searches.

Data Screening

One hundred and thirty-nine duplicate papers were identified using Rayyan Intelligent Systematic Review software, checked manually, and then deleted. This left 582 titles and abstracts to be screened against the inclusion and exclusion criteria. Four hundred and eighty-nine papers were excluded at this stage. The remaining 46 papers were read in full, and twenty-five papers met the full criteria for inclusion. A review of the reference lists of the included papers identified six additional papers which were screened. One additional paper met the requirements, bringing the total number of eligible studies to 26 (full process provided in figure 2). A senior research associate at an independent university screened six papers against the inclusion and exclusion criteria. Inter-rater reliability was calculated using Cohen's kappa (k = 1). Included papers are presented in Table 3, and a summary of key information in Table 4.

Figure 2

Summary of the data sampling and screening procedure

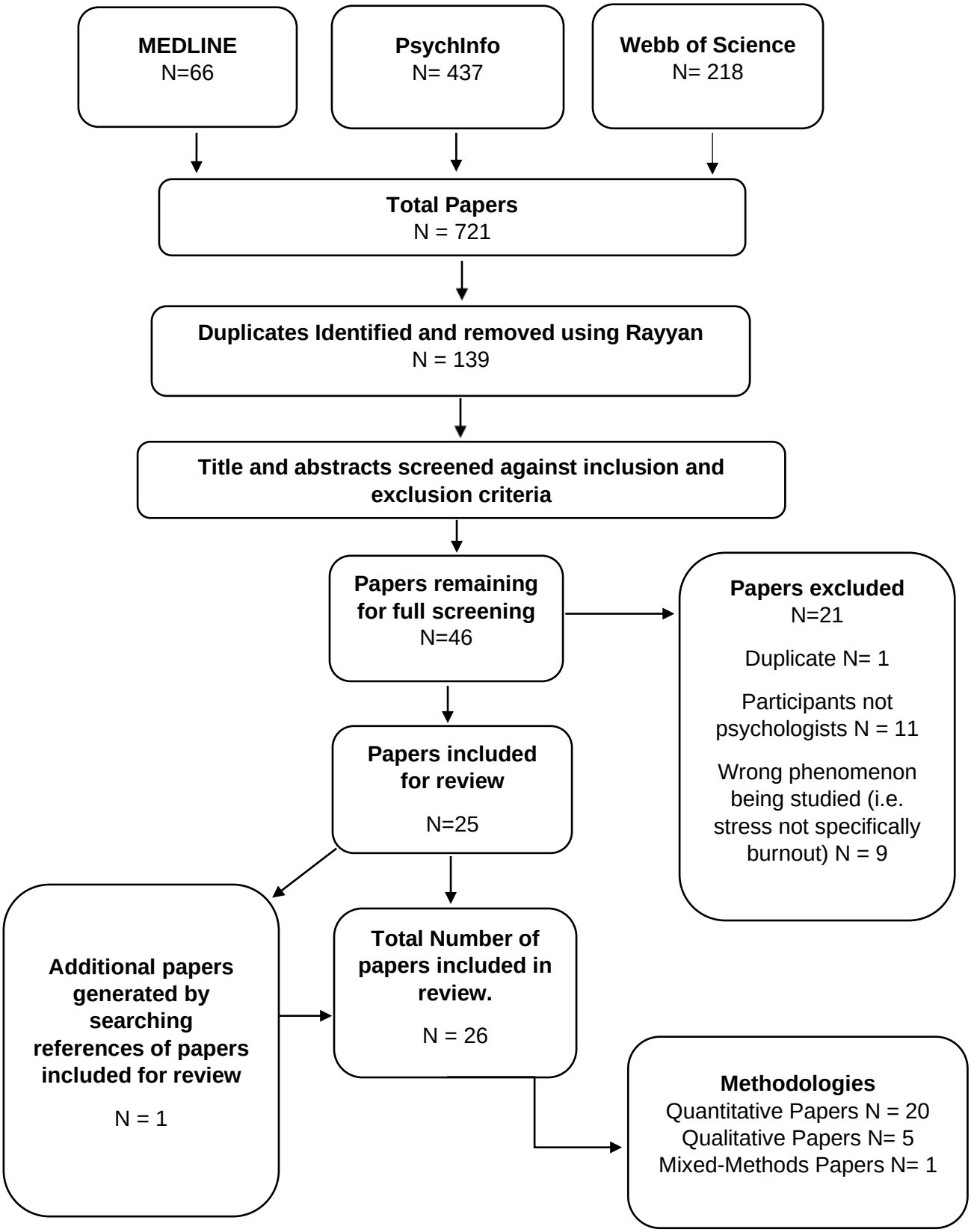


Table 3

Authors, publication year, titles of included papers and geographical population in Alphabetical Order, by Author

Author and Year of Publication	Title	Title	Geographical Population
Ackerley et al., 1988	#1	Burnout among licensed psychologists	USA and Canada
Allwood et al., 2022	#2	The relationship between personality, work, and personal factors to burnout among clinical psychologists: exploring gender differences in Sweden	Sweden
Berjot et al., 2017	#3	Burnout risk profiles among French psychologists	France
Clarke et al., 2021	#4	The perceived effects of emotional labour in psychologists providing individual psychotherapy	Australia
Di Benedetto and Swadling 2014	#5	Burnout in Australian psychologists: Correlations with work-setting, mindfulness and self-care behaviours	Australia
D'souza et al., 2011	#6	The relationship between perfectionism, stress and burnout in clinical psychologists	Australia

Emery et al., 2009	#7	Associations among therapist beliefs, personal resources and burnout in clinical psychologists	Australia
Hammond et al., 2018	#8	A thematic inquiry into the burnout experience of Australian solo-practising clinical psychologists	Australia
Keading et al., 2017	#9	Professional burnout, early maladaptive schemas, and physical health in clinical and counselling psychology trainees	Australia, USA, Canada, UK
Kahill., 1986	#10	Relationship of burnout among professional psychologists to professional expectations and social support.	Canada
Malinowksi., 2013	#11	Characteristics of job burnout and humour among psychotherapists.	USA
McCade et al., 2021	#12	Burnout and depression in Australian psychologists: The moderating role of self-compassion	Australia
McCormack et al., 2015	#13	Practicing what we preach: investigating the role of social support in sport psychologists' well-being	USA, UK, Ireland, Australia, New Zeland

Rodrigeuz and Carlotto., 2017	#14	Predictors of burnout syndrome in psychologists	Brazil
Roncalli and Byrne., 2016	#15	Relationships at work, burnout and job satisfaction: A study on Irish psychologists.	Ireland
Rupert and Kent., 2007	#16	Gender and work setting differences in career-sustaining behaviours and burnout among professional psychologists	USA
Rupert and Morgan., 2005	#17	Work setting and burnout among professional psychologists	USA
Rupert et al., 2009	#18	Work-family conflict and burnout among practising psychologists	USA
Sadusky and Spinks., 2022	#19	Psychologists' engagement in reflective practice and experiences of burnout: a correlational analysis	Australia, UK and New Zeland
Simpson et al., 2019	#20	Burnout amongst clinical and counselling psychologists: The role of early maladaptive schemas and coping modes as vulnerability factors	Open Globally: Countries listed Australia, New Zealand, UK, Neatherlands, USA, Canada and 'Others'
Sim et al., 2016	#21	Thriving, burnout, and coping strategies of early and later career counselling centre	USA

		psychologists in the United States	
Skorupa and Agresti., 1993	#22	Ethical beliefs about burnout and continued professional practice	USA
Smout et al., 2022	#23	The influence of maladaptive coping modes, resilience, and job demands on emotional exhaustion in psychologists	Australia and UK
Turnball & Rhodes., 2021	#24	Burnout and growth: Narratives of Australian Psychologists	Australia
Vrendenburg et al., 1999	#25	Burnout in counselling psychologists: Type of practice setting and pertinent demographics.	USA
Williams et al., 2020	#26	Psychologists' practices, stressors, and wellness in academic health centres.	USA

Table 4

Summary of Key Aims, demographics, and methodologies of included papers, in Alphabetical Order, by Author

Paper ID	Aims	Design and Method	Participant Demographics	Findings	JBI Score	Risk of Bias and Limitations
#1	Examine the level of burnout and correlates of burnout.	ANOVA and Multiple Regression.	562 Doctoral Level Licensed Psychologists 73% Male 27% Female.	Reported that burned-out clinicians were likely to be young, low earners, not engaged in psychotherapy, experienced feelings of lack of control and were over-involved with client work.	6/8	Researchers do not state if this gender split is representative of the field. Psychologists experiencing burnout may not have responded to the request. Cross-sectional data cannot provide insight into causation.
#2	Investigate the effects of gender, personality, job demands, affective work rumination and personal-	Hierarchical multiple regression analyses	828 Clinical Health Psychologists 78% Female 22% Male.	Many factors impact burnout, including gender, work-rumination, conflict, and exhaustion.	6/8	Inclusion/Exclusion criteria are not clearly stated, and the period for data collection is unknown. Cross-sectional data cannot provide insight into causation.

	to-work conflict on burnout.					The population of people identifying with neither gender was not large enough for analysis.
#3	Identify profiles at risk of burnout.	Hierarchical cluster analysis. Two-way ANOVA.	664 Qualified Psychologists 9.9% Male 90.1% Female.	Age, work environment, and work demands were all associated with burnout in psychologists.	7/8	The sample may have overrepresented female psychologists. Provide findings related to seniority, but it's unclear what authors classify seniority.
#4	To explore emotional labour and burnout in psychologists who provide individual therapy.	Thematic Analysis.	24 Psychologists grouped into Early career psychologists (N= 9), Mid-Career Psychologists (N=7) and Experienced Psychologists (N=8)	The increased emotional intensity of clinical work is linked to higher levels of emotional exhaustion and the need to distance oneself from work-related emotions.	10/10	Did not capture the views of those who may have left direct clinical roles due to burnout. The sample was restricted to western Australia.

#5	To investigate the relationships between burnout, work-setting, years of experience in that setting, mindfulness, and career-sustaining behaviours (CSBs).	One-way between-subjects ANOVA.	167 Registered Psychologists 86.8% Female 13.2% Male.	Psychologists with less time and experience in their posts have higher rates of burnout. Increased mindfulness skills are linked to lower levels of burnout.	6/8	Recruitment through registration bodies may not capture. Psychologists who have burnt out and may have left the profession and no longer hold a professional registration.
#6	To examine the relationship between perfectionism, stress and burnout.	Regression Analysis.	87 Clinical Psychologists 86% Female 14% Male	Perfectionism was directly and indirectly related to the development of burnout.	7/8	Relatively small sample, not adequate to conduct regression analyses.
#7	To Examine the contribution of demographics, workplace variables, and individual factors to burnout.	Factor Analysis and Multiple Regression.	190 Clinical Psychologists 71.6% Female 27.9% Male 5% unaccounted for.	Being female, working for the government, having fewer personal resources, and having beliefs about clients were linked to higher levels of emotional exhaustion.	7/8	Only 11-34% of the variance of each burnout scale is accounted for. Psychologists' level of cognitive training was not considered. Can't inform the direction of the relationship, i.e., whether therapist beliefs and lack of coping resources cause work stress or vice versa.

#8	To examine the different experiences of burnout across Australian psychologists.	Thematic Analysis	6 Clinical Psychologists	Psychologists reported excessive workload and hours of work, life stresses, mismanagement, and transference between clients' and their psychologists as factors related to burnout.	9/10	Limited sample. Only recruited participants currently practising, missed the opportunity to capture those who may have ceased practice due to burnout. No statement locating the researchers culturally or theoretically in relation to their research.
#9	To explore the relationship between Early Maladaptive Schema (EMS) and burnout.	Discriminant function analysis	1172 Clinical and Counselling Trainee Psychologists 82.3% Female 17.7% Male	High burnout was associated with a higher level of physical health problems and greater endorsement of all Early Maladaptive Coping Styles, but only the unrelenting standards were found to be a significant predictor of burnout.	6/8	Psychologists in this study were not screened for pre-existing health conditions. The study was subject to response bias, whereby participants may have underreported some EMSs and endorsed EMSs they perceived as culturally acceptable—concerns about being labelled incompetent etc.
#10	To explore burnout in relation to social support	Pearson's correlations	225 Trainee, newly qualified	Burnout is significantly related to social support	6/8	Limited sample from a small geographical area. Inclusion

	in private life and expectations or attitudes about the profession. To compare burnout experiences across varying professional experience.	and univariate ANOVA	and experienced psychologists. 'Roughly equal' proportions of Male and female.	from family and friends and expectations or attitudes about the profession.		/Exclusion criteria are not stated. Researchers have identified confounding factors but do not appear to have controlled for these during the analysis.
#11	To explore the relationships between types of humour and characteristics of job burnout.	Stepwise Regression and Bivariate Correlation Analysis	133 Psychologists 68.4% Female 31.6% Male	Self-defeating humour contributed to higher levels of emotional exhaustion and depersonalisation. Self-enhancing humour contributed to higher levels of personal accomplishment.	7/8	Using purposive sampling, those who responded were likely to have an interest or connection to the research topic. Relationships are moderate. Variables needed to be transformed to perform the statistical analysis, which may have affected the outcome. Causality cannot be determined.
#12	To examine the relationships between self-compassion, depression and burnout.	Hierarchical linear regression.	259 Psychologists 40% Female 60% Male	Self-compassion mediated levels of burnout and depression in psychologists. Higher self-compassion was linked to lower levels of	6/8	The cross-sectional study design cannot comment on causality. There may be other explanations accounting for the relationship

				burnout and fewer depressive symptoms.		between burnout, depression, and self-compassion, not considered in the research.
#13	To explore the experience of burnout in sports psychologists	Thematic Analysis	30 Sports Psychologists	Burnout is frequently experienced despite psychologists experiencing high levels of work engagement—lower levels of social support are associated with higher levels of burnout.	8/10	No statement positioning the researchers or exploration of their impact on the data collection and analysis.
#14	To identify individual variables and job characteristics that can predict burnout in psychologists.	Multiple Linear Regression Analysis (Stepwise)	518 Psychologists 1 year + post-qualification 77% Female 23% Male	The strongest factors linked to burnout dimensions were overwork and emotion-focused coping strategies. Burnout occurs due to the overlap of personal and work-related variables.	6/8	A cross-sectional design, which does not allow for causal conclusions. Again, this highlights the "healthy worker effect," which may underestimate the magnitude of the identified risks.

#15	Examine the levels of job satisfaction and burnout among psychologists working in Irish community mental health teams (CMHTs).	Hierarchical Regression Analysis and Thematic Analysis	77 Psychologists 76.6% Female 23.4% Male	Relational aspects of psychologists' jobs and job satisfaction are significant factors in the development of burnout.	6/8 7/10	The low response rate and consequent small sample size limit the possibility of generalising the results in terms of the representativeness of the wider population of CMHT psychologists. The small sample size also limited the choice of data analyses that could be used, prohibiting the reliable testing of more comprehensive models. Cross-sectional, no causal relationships
#16	To examine gender differences in burnout, work activities and demands, and work resources in independent practice and agency settings.	Analysis of Co-variance (ANCOVA) and Pearson Correlations.	595 Psychologists 58.3% Female 41.7% Male	Female agency psychologists experience higher levels of emotional exhaustion. Working in agency settings is associated with higher levels of burnout.	6/8	Did not include psychologists whose primary work setting was not clinical. It may have excluded psychologists who had left clinical fields due to burnout. Restricted to clinical and counselling psychologists may not represent a wider discipline. Confounding

						variables are not fully identified and explained.
#17	To examine the relationship between work setting and burnout	Analysis of co-variance (ANCOVA) and Pearson correlations.	571 Psychologists 54.3% Female 45.7% Male	Higher levels of emotional exhaustion were associated with less control over work activities, working more hours, spending more time on administrative tasks and paperwork, and engaging with challenging clients	7/8	It doesn't define what is meant by the different work groups. They also don't explain how they managed individuals who might hold dual roles. One criterion was identified as a clinical setting as their primary place of employment; they may not capture psychologists who have left clinical settings due to burnout.
#18	To explore gender and work-setting interactions on emotional exhaustion and work-setting differences in resources and demands that relate to burnout	Analysis of Co-variance (ANCOVA)	421 Psychologists 57.9% Female 42.4% Male	Family support was important for work-related well-being; however, conflict between work and family domains was associated with burnout.	7/8	The sample was majority white, based on Eurocentric family ideas.

#19	To investigate the relationships between psychologists' burnout levels and reflective practices.	Pearson's Correlation	120 Qualified Psychologists 83.3% Female 16.7% Male	Burnout was associated with the level of job satisfaction and stress interacting with clients. The importance of adequate supervision was highlighted as a key finding.	6/8	The majority of respondents were from Australia, making it difficult to generalise to other countries. Non-experimental design of this study prevented the researchers from establishing causality or creating a predictive model between RP and burnout variables.
#20	To examine the work setting, main sources of stress, and prevalence of burnout. To identify the predominant Early Maladaptive Schema's (EMS) and Maladaptive Coping Modes (MCM).	Pearson Correlation and Hierarchical regression	443 Fully registered clinical and counselling psychologists	Coping modes of detached protector and detached self-soother were most frequently observed in burnout psychologists.	6/8	50% of the sample were Australian. the cross-sectional design of this study prevents attributing causality in the relationships. The SMI version used in this study measures only a small subset of the coping modes that researchers have since identified.
#21	To explore factors contributing to burnout, specifically, stage of career.	Consensual Qualitative	14 Psychologists	Factors related to burnout included challenges with tasks and responsibilities and	10/10	Participants with extremely distressing experiences or neutral experiences may not have responded to the advert.

		Research methodology		interpersonal relationships.		Snowballing, so unable to detail how representative the sample is. Researchers with a connection to the participants completed some coding.
#22	To investigate the relationships between psychologists' beliefs of burnout and experience of burnout.	Principal-components factor analysis Pearson correlational coefficients	94 Psychologists	Psychologists who believe more strongly that it is unethical to practice whilst experiencing burnout see fewer clients than psychologists who believe this less strongly.	6/8	The sample was skewed due to self-selection bias; those who experienced higher burnout may have chosen not to participate. Reliability estimate was relatively low.
#23	To understand the influence of maladaptive coping modes, resilience and job demands on emotional exhaustion	Hierarchical regression analyses	425 Counselling and Clinical Psychologists 80.7% Female 19.03% Male	Maladaptive coping modes contribute to the development of burnout in psychologists.	6/8	A convenience sample of psychologists. Cross-sectional, no implications of causality. The sample size was adequate, but it may still have been underpowered to detect interactions.

#24	To explore the lived experiences of psychologists in relation to burnout	Thematic Narrative Enquiry	17 Psychologists. 82.4% Female 17.6 Male	Participants described high workload/ demands, lack of job clarity, autonomy, respect, and personal difficulties as factors in their experience of burnout.	9/10	Didn't capture the experiences of psychologists who had left the profession due to burnout. There was a significant difference in the average age of the groups; the burnout group were older. Cultural theories were not used in the analysis to explore sociocultural processes.
#25	To examine relationships between burnout and type of work setting, hours of client contact, years in present position, and years employed with current organisation	Multiple Regression Analysis	521 Doctoral Level Counselling Psychologists 64% Female 36% Male	Psychologists in private practice reported the lowest levels of burnout. Psychologists in hospital settings reported the highest levels of burnout. Working more hours a week was linked to higher levels of personal accomplishment. Lower age is linked to higher burnout.	6/8	Didn't capture the experiences of psychologists who had left the profession due to burnout. The gender split is not representative of national demographics for psychologists.

#26	To investigate sources of stress and burnout in practising psychologists.	Between Group ANOVA	93 Psychologists 67% Female 43% Male	A high workload was associated with burnout, and burnout was associated with decreased professional satisfaction.	6/8	Modest sample size. Exploratory cannot describe causality. Burnout measure was designed for the study and therefore has not been validated.

Quantitative
Qualitative Data
Mixed Methods Study

Quality Summary

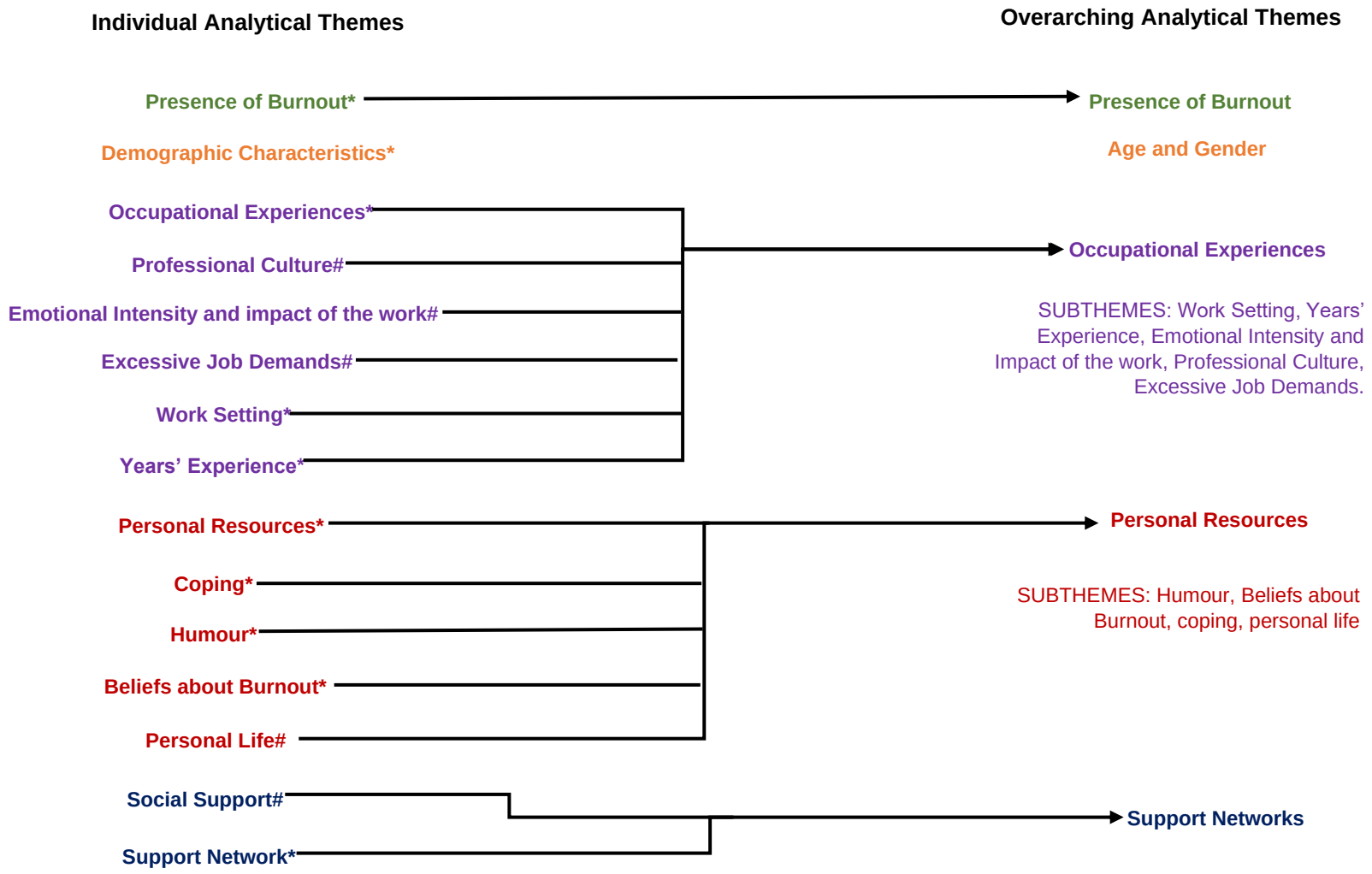
All papers were rated as high quality. The lowest scores for qualitative papers were 7/10 and 6/8 for quantitative papers. Across the included papers, the risk of bias and limitations were commonly noted concerning the participants. Several studies only recruited psychologists currently registered or practising clinically, which means that psychologists who had potentially left their roles due to burnout were not captured in the data (#5, #8, #14, #16, #17, #21, #24, #25). A lack of a reflexivity statement from the researchers was a common quality issue for the qualitative papers (#8, #13), while insufficient detail regarding the management of confounding variables was noted for several quantitative papers (#9, #10, #16, #25).

Narrative Synthesis

This review aimed to establish the prevalence, causes and factors related to burnout in psychologists. The thematic synthesis included the experiences of 8,256 psychologists. Ten initial quantitative themes and five qualitative themes emerged from the extracted data (Appendix F). The five overarching themes are presented below (Figure 3).

Figure 3

Summary of the theme merging process



Quantitative themes are marked with a *
Qualitative themes are marked with a #

Theme 1: Presence of Burnout

There was a lack of homogeneity of burnout measures used across the studies, as shown in Table 5. Except for #14 and #19, all quantitative papers provided information regarding the burnout rate within their sample. The 91 participants in the qualitative studies all self-reported experiencing burnout; however, this was a criterion for participation.

Table 5

Burnout Measure Information, Presented Alphabetically.

Burnout Measure	Dimensions Measured by Tool	No. of Papers	Paper IDs	Papers not reporting prevalence data
Copenhagen Burnout Inventory (CBI)	Personal burnout, work-related burnout, client-related burnout	4	#5, #6, #12, #19	#19
Maslach Burnout Inventory (MBI)	Emotional exhaustion, depersonalisation, and personal accomplishment	10	#1, #3, #7, #11, #15, #16, #17, #18, #22, #25	N/A
Maslach Burnout Inventory – Emotional Exhaustion Scale	Emotional Exhaustion	3	#9, #20, #23	N/A
Shirom-Melamed Burnout	Assesses exhaustion across physical, cognitive, and emotional subscales.	1	#2	N/A

Questionnaire (SMBQ)				
Tedium Burnout Measure (TBM)	Cognitive weariness, fatigue, emotional exhaustion	1	#10	N/A
Job Burnout Syndrome Assessment Questionnaire (JBSAQ)	Enthusiasm toward the job, psychological exhaustion, indolence, guilt.	1	#14	#14
Purpose Designed Burnout Measure (PDBM)	Four items assessed wellness: two addressed burnout, and two assessed career satisfaction.	1	#26	N/A

The majority of the quantitative papers (#1, #3, #11, #15, #16, #17, #18, #22, #25) reported average scores for each dimension of burnout compared to the standardised norms for mental health practitioners, whilst papers #9, #20, and #23 reported average scores based on general population norms. The remaining studies reported the number of participants meeting category cut-off scores.

Copenhagen Burnout Inventory. Across the three studies, rates of overall burnout ranged quite significantly from 8%–30% of the participants; however, for two studies which reported burnout by category, work-related burnout was particularly prevalent, with an average of just under 50% (200) of participants meeting criteria for this (Table 6).

Table 6

Burnout Data from Studies using the CBI.

Paper ID	Levels of Burnout per Dimension	Overall Burnout
#5	Over 35% met the criteria for Personal Related Burnout. Over 51% met the criteria for Work-related burnout.	Less than 15% met the criteria for overall burnout
#6	Not Reported	8% Met the criteria for overall burnout
#12	Over 20% met the criteria for Personal Related Burnout. Over 42% met the criteria for Work-related burnout.	30% of participants met the criteria for overall burnout

Maslach Burnout Inventory. Though findings around personal accomplishment and depersonalisation were mixed, participants consistently fell in either the moderate or high burnout category for emotional exhaustion (Table 7 and figure 4). Only #7 and #25 were limited to one psychological discipline (clinical and counselling); other papers included Psychologists from a range of disciplines. The thirteen studies also represented findings encompassing several countries, including the USA (#1, #9, #11, #16, #17, #18, #20, #22, #23, #25), Canada (#9, #20), Australia (#7, #9, 20, #23), UK (#9, #20, #23) France (#3) and Ireland (15). All participants were contacted via their professional registration body and volunteered to complete online or postal surveys, so careful consideration of sampling biases weighted towards those with an invested interest or experience of burnout must be considered alongside findings relating to prevalence.

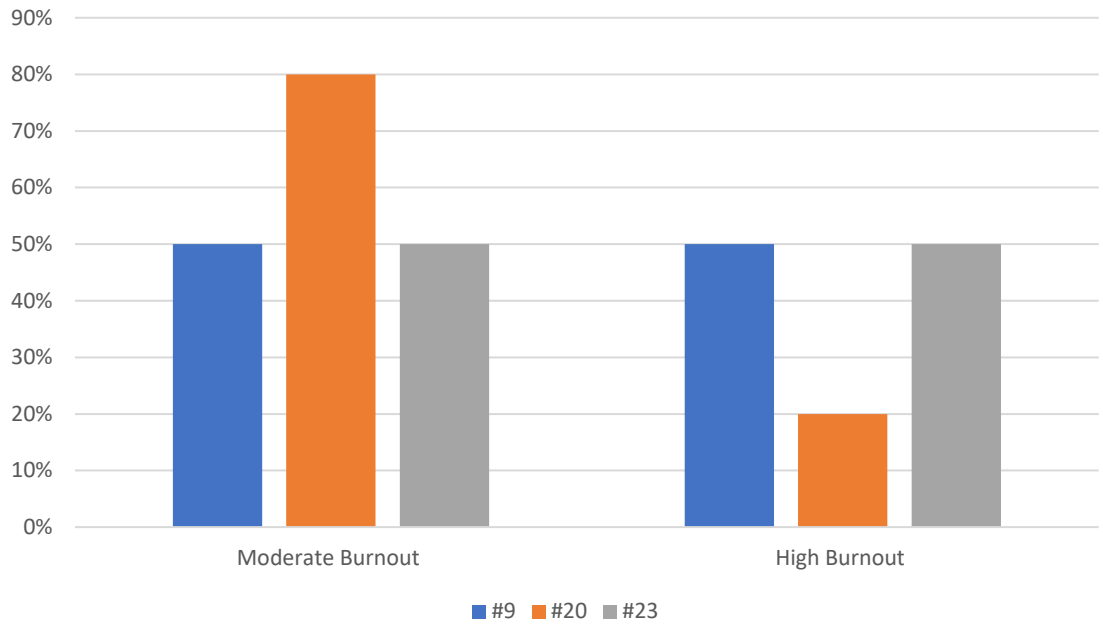
Table 7

Burnout Data from Studies Using the MBI Full Scale

Paper ID	Emotional Exhaustion Mean (SD)	Depersonalisation Mean (SD)	Personal Accomplishment Mean (SD)	Level of Burnout using the standard Norms for Mental Health Practitioners (MBI-MH-S)
#1	19.44 (9.31)	6.31 (4.48)	42.27 (4.52)	EE: Moderate Burnout DP: Moderate Burnout PA: Low Burnout
#3	24.50 (8.49)	9.41(3.80)	33.76 (5.13)	EE: High Burnout DP: High Burnout PA: Moderate Burnout
#7	Not provided	Not provided	Not provided	Below (Stated by the researcher)
#11	Not provided	Not provided	Not provided	Low Burnout (Stated by the researcher)
#15	15.73 (7.5)	3.15 (2.8)	37.62 (4.91)	EE: Moderate Burnout DP: Low Burnout PA: Low Burnout
#16	17.75 (9.16)	4.81 (3.76)	41.56 (4.88)	EE: Moderate Burnout DP: Moderate Burnout PA: Low Burnout
#17	19.99 (9.83)	5.21 (4.26)	41.64 (4.78)	EE: Moderate Burnout DP: Moderate Burnout PA: Low Burnout
#18	16.41 (8.79)	4.42 (3.69)	42.59 (4.45)	EE: Moderate Burnout DP: Moderate Burnout PA: Low Burnout
#22	Not provided	Not provided	Not provided	Low Burnout (Stated by the researcher)
#25	17.83 (8.90)	8.90 (4. 10)	42.09 (4.53)	EE: Moderate Burnout DP: High Burnout PA: Low Burnout

Figure 4

Burnout Data from Studies Using the MBI Emotional Exhaustion Scale



SMBQ, TMB, and the Purpose-Designed Questionnaire. 179 of the 828 participants in study #2 scored above the SMBQ cut-off for severe burnout, but they did not report how many met the criteria for mild-moderate burnout. The overall level of burnout in study #10 fell in the low-moderate range for the TMB, with only 14 of the 225 participants in the severe range. 31 of the 93 participants in study #26 described persistent burnout symptoms on the purpose-designed questionnaire.

Though there was variation in the overall level of burnout across the studies, many studies highlighted psychologists experiencing moderate to high levels of emotional exhaustion, whilst work-related burnout was common amongst Psychologists completing the CBI.

Theme 2: Age and Gender

Eleven quantitative studies reported findings related to age and gender (Table 8).

Table 8

Findings relating to Burnout, Age and Gender

Paper ID	Burnout Measure	Findings Relating to Age	Finding Relating to Gender
#1	MBI	Younger Psychologists experience greater EE compared to older colleagues	
#6	CBI	Younger Psychologists reported higher levels of burnout	
#7	MBI		Higher levels of EE in women
#16	MBI		Women in agency settings experience higher EE than men and women in other settings
#17	MBI		Women in agency settings experience higher EE than men and women in other settings
#18	MBI		No difference between burnout in men and women in agency settings
#25	MBI	Age inversely correlated with EE	Male Psychologists reported higher levels of depersonalisation compared to female

Younger psychologists report higher levels of EE and may, therefore, be at greater risk of burnout than their older counterparts. This finding was consistent across studies despite researchers using different burnout measures and focusing on different burnout dimensions. The studies also covered a broader range of PPN disciplines, with #1 focused on all Psychologists with a doctoral qualification, clinical (#6) and counselling (#25) psychologists; however, the population is limited to North America and Australia.

Results collected using the MBI suggest that women are at a greater risk of EE than male Psychologists. Women in non-permanent roles, such as agencies, may be at elevated risk of EE; however, as you can see from table 8, this finding was inconsistent across studies of participants in the USA (Zippia., 2023). Notably, 73% of the participants in paper #1 were male. This is three times higher than North America's national percentage of male psychologists. Thus, findings may over-represent the experiences of North American male psychologists. The gender split in all other contributing studies represented their wider psychological populations.

Theme 3: Occupational Experiences

Subthemes relating to occupational experiences across the qualitative and quantitative data have overlapping and complementary findings, presented below.

Work Setting (Quantitative). All the papers used the MBI to measure burnout; findings are presented in Table 9. Findings suggest that psychologists working in agency settings and government mental health services may be at

greater risk of burnout than their colleagues in other settings. All studies were conducted with USA populations, except for #1, which also included Canadian psychologists and #7, which was conducted with an Australian population.

Table 9

Findings relating to burnout and workplace setting.

Paper ID	Burnout Measure	Finding
#1	MBI	Psychologists in private practice had lower rates of EE and DP and higher PA than Psychologists in other settings
#7	MBI	Psychologists in Government mental health services at an increased risk of EE, DP and PA
#16	MBI	Psychologists working in agencies reported greater stress and lower levels of PA
#17	MBI	Psychologists working in agencies reported greater stress and lower levels of PA
#18	MBI	Psychologists working in agencies reported greater stress and lower levels of PA
#22	MBI	Psychologists in Government mental health services at an increased risk of EE, DP and PA
#25	MBI	In a comparison of burnout across workplaces: Psychologists in mental health services have the highest rates of depersonalisation, private Psychologists had the lowest rate

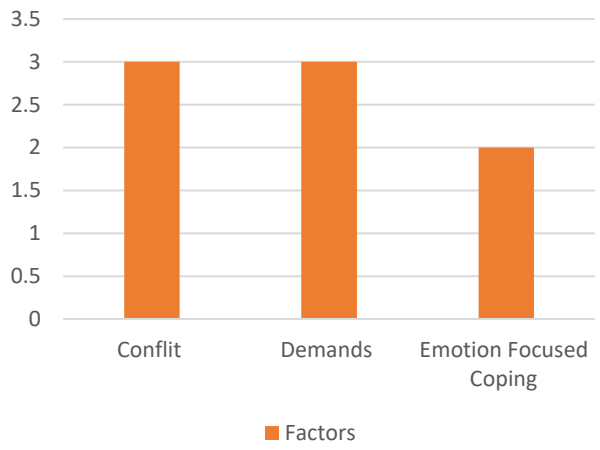
Years Experience (Quantitative). This review found evidence that fewer experienced psychologists experience greater emotional exhaustion and

depersonalisation compared to their more experienced colleagues (#1, #5); however, no difference in experience was highlighted by paper #10, suggesting a potential role for inexperience in the role of burnout.

Emotion-Focused Factors (Qualitative and Quantitative). Twelve papers, six quantitative and six qualitative, highlighted the emotional intensity and subsequent impact of clinical work as an important factor in Psychologists' development of burnout (Figure 5).

Figure 5

Graph showing the number of quantitative studies providing evidence for the relationship between burnout and emotion-focused factors



The quantitative data was collected across the MBI, SMBQ, and JDSAQ and represented several disciplines of Psychologists across Brazil and Ireland, but primarily North America.

The qualitative data also reflected this theme. Psychologists reported that high workloads, excessive demands, and insufficient time to complete their work were all related to burnout. There were several references to

psychologists working over their contracted hours to complete their work on time and describing their job demands as 'just too much' (Hammond et al., 2018, P.8). One participant explained the impact of these demands and how it led to their burnout saying 'I stopped doing things the best I could and just doing things to get them done' (McCormack et al., 2015, P.6).

Managing the complex emotions arising from clinical work was a significant factor in developing burnout.

> *'what contributes to burnout is seeing clients who really push your buttons', 'There's that compassion fatigue thing, it's just too much sometimes'. (Clark et al., 2021, P. 419)*

Psychologists' work also appeared to have an impact on their home lives. Several participants across studies described feeling unable to show their family and friends the kind of emotional responses that they would like to.

> *'I'm like a Zombie at the end of the day… I want to have emotion and show you that, but I've literally got nothing left in the tank'. (Clark et al., 2021, P. 420)*

Professional Culture (Qualitative). Participants across all of the qualitative studies referred to a lack of discussion and acknowledgement during their professional training of the risks of burnout in psychologists. One participant illustrated this by saying, 'They didn't even tell us about burnout…so I didn't even realise it was something that happened' (Hammond et al., 2018, P. 6).

Similarly, recurrent references were made regarding a lack of discussion about how to seek support for burnout, with many reporting a stigma around

psychologists asking for help. There were several references to the expectations on psychologists to 'perform well, be strong, avoid mistakes at all costs, learn from their experiences and maintain professionalism' (Hammond et al., 2018, p. 6). All studies noted that participants believed the client's needs were more important than their own. This left many psychologists feeling overwhelmed by their roles and perceived pressure to perform. Several participants commented on the impact this had on their ability and willingness to take annual leave, which is captured well by a quote from one participant who said, 'I felt stressed leading up to my holiday, I felt so guilty about taking a break from work'.

Theme 4: Personal Resources

Humour (Quantitative)*.* Two studies explored the role of humour in burnout development, reporting statistically significant relationships. Paper #5 found that maintaining a sense of humour was inversely correlated with overall levels of burnout, though this association was relatively small. Similarly, paper #15 explored different types of humour and reported that self-defeating humour was linked to high emotional exhaustion and depersonalisation levels. There were some positives associated with humour in this sample. Adaptive forms of humour, such as affiliative and self-enhancing humour, were highly associated with personal accomplishment.

Beliefs about Burnout (Quantitative)*.* Only one paper (#23) explicitly examined participants' beliefs about burnout in relation to their experience. They found that psychologists who believed more strongly that practising psychotherapy whilst experiencing burnout was unethical had more knowledge

about preventing burnout and saw fewer clients per week than those who did not believe it was unethical. They concluded that beliefs about burnout could impact a person's behaviours at work and, ultimately, their likelihood of experiencing burnout.

Coping (Quantitative). Amongst the eligible papers, there was a particular focus on early maladaptive schemas (Bach et al., 2018) and maladaptive coping modes (MCM)(Simpson et al., 2018) in relation to burnout. In study #9, the high burnout group reported higher mean scores on all 15 EMSs than the low burnout group. All 15 EMSs significantly predicted participants' level of burnout more accurately than by chance. Both paper #9 and paper #20 reported that self-sacrifice and unrelenting standards schemas were the most frequently reported schemas amongst participants with higher burnout. Paper #20 also reported that all EMSs and MCMs were positively correlated with emotional exhaustion. Similarly, paper #23 found that each MCM contributed to predicting participants' levels of emotional exhaustion above the influence of job demands and resilience.

One paper (#12) explored the relationship between self-compassion and burnout. Their findings indicated that psychologists with lower levels of self-compassion experience higher levels of burnout and more depressive symptoms. An additional paper (#5) found a strong negative correlation between the level of burnout and mindfulness, which led them to conclude that psychologists with fewer mindfulness skills experience higher burnout.

This review suggests that personal factors may play a role in developing burnout. Several factors were identified, but there were insufficient papers

examining each factor to draw clear conclusions about how important each factor may be.

Personal Life (Qualitative). A clear theme across the six qualitative data sets related to life outside of participants' work as psychologists, A contributor to burnout in all groups was personal difficulties and challenges. All the papers acknowledge that external stressors, personal circumstances or life changes (such as pregnancy, divorce or transitional ages) were linked to participants' burnout experiences. One participant summarised the intersection between their experience of work-related burnout and challenges at home as 'the perfect storm' (Turnbull & Rhodes., 2021, p. 55).

There is a clear argument that challenges or significant changes in a person's personal life can impact their risk of developing burnout. It is important to note that none of the studies collected information on participants' mental health, which would be a confounding factor in this finding.

Theme 5: Support Networks

Social Support Networks (Quantitative and Qualitative). Three qualitative papers explored burnout-related social factors, primarily social support and family-work conflict. Paper #10 found that higher levels of burnout were associated with less social support, less optimistic expectations, and higher levels of work-related disillusionment. Regarding work-life balance, higher work-family conflict was associated with a lower sense of personal accomplishment, greater emotional exhaustion and depersonalisation of clients. Three of the core dimensions of burnout, according to the MBI. Discussing work frustrations with family, friends or colleagues was associated with higher levels

of burnout (paper #5); however, as this study was cross-sectional, it is unclear whether discussing burnout with others is the cause or effect of burnout.

These findings were complemented by the qualitative findings, which highlighted the positive significance of the role of the clinical supervisor. Several participants explained that complicated relationships with supervisors contributed to burnout as they relied on supervision as a safe and containing space to manage the difficulties that arose from their work. Without this, the work environment felt more challenging. Moreover, many spoke of the critical relationship played by family and friends in managing burnout or avoiding it altogether. This led many authors to conclude that lacking adequate social support is a risk factor for developing burnout in psychologists. Interpersonal relationships and the support networks they provide are important protective factors in psychologists' experience of burnout.

Cross-Cultural Considerations.

The findings capture the experiences of psychologists working in nine countries. Their experiences will be impacted by their varied cultural backgrounds, including different training pathways, healthcare systems and broader socio-cultural contexts.

Language in Burnout Measures. Cross-cultural considerations may impact the interpretation of the synthesised data. The conceptualisation of burnout and the language used to represent and express the concept are particularly important (Squires et al., 2014). For example, dimensions of the MBI such as depersonalisation may not exist linguistically or culturally in countries where English is not the primary language, such as Sweden (#2), Netherlands

(#20), Brazil (#14), France (#3) and the Canadian province of Quebec (#1, #9, #10, #20). Many of these studies reported using English language outcome measures. This may impact the rigour of the outcome measure in detecting the prevalence of burnout across the studies in this review (Maneesriwongul & Dixon., 2004). As such, the conclusions in this study must be held tentatively and consider the cross-cultural differences in the language used to define and identify burnout.

Healthcare Systems. There are significant differences in the psychology and healthcare structures in the USA, Australia and the UK (Papanicolas et al., 2018), the primary contributors to these themes relating to work settings. Australia operates a shared public-private system where eligible residents can access government healthcare free of charge (Duckett & Wilcox., 2015). The USA has a more complex and primarily private medical system where government-provided care for eligible individuals is provided at reduced or no cost (Obama., 2016). On the other hand, the UK has a National Health Service, free at the point of delivery (Bacon et al., 2022). The difference in how services are designed, funded and delivered across the study populations will likely impact the experience of working in a particular professional context. Agency psychologists in America are likely to experience different stressors than agency psychologists in Australia, as these agencies provide different services under varied funding structures. Thus, the term ‘agency’ in this study encompasses a wide range of working arrangements which differ cross-culturally.

Psychology Training Pathways. Training pathways vary significantly across the nine countries. In the UK (Nel et al., 2012) and the USA (Norton et

al., 2022), qualified psychologists usually must complete a doctoral-level qualification. In Australia, qualified psychologists hold a post-graduate diploma (Norton et al., 2022), whilst, in Sweden (Allwood et al., 2022) and France (Moser & Rouquette., 2002), an MSc and proof of experiential learning are accepted for professional registration. These differences in training experiences are likely to mean that the professional culture of psychology, the age of newly qualified psychologists and a variety of other aspects of the experience of psychologists will differ across the countries. Thus caution must be employed when interpreting these results relating to occupational experiences, and it must be acknowledged that they represent data from several distinct professional cultures and not one collective.

Discussion

This systematic review synthesised international data related to the prevalence, factors and causes of burnout in psychologists. The review findings suggest that psychologists across North America and Europe may experience moderate to high levels of emotional exhaustion compared to standard norms for mental health practitioners. Age, gender and years of experience were all found to be important factors in the development of burnout. Occupational experiences, such as job demands and personal resources, such as ways of coping, also appeared to play an important role. Positive support networks were critical in minimising psychologists' experience of burnout. Findings are discussed in the context of existing research and the potential clinical implications.

Findings suggest that psychologists may experience higher levels of

emotional exhaustion than their mental health colleagues. Given that psychologists often work with clients experiencing high levels of, this finding is not unsurprising (Rupert & Dorociak., 2019). Although, some researchers argue that the emotional exhaustion scale of the MBI is the only sub-scale sensitive enough to capture burnout and, as such, may account for the higher levels of emotional exhaustion compared to depersonalisation and personal accomplishment (Smout et al., 2022). Reliably integrating findings from studies using different outcome measures was a significant challenge in this review as the dimensions of burnout being measured differ too significantly to compare, e.g. emotional exhaustion compared with personal, professional, and work-related burnout. As a result, findings are based on just 13 of the total 26 studies which reported burnout in their samples and must be held tentatively.

None of the eligible studies examined the national prevalence of psychologist burnout in the UK. Accessible and reliable prevalence data is essential in understanding the progression of conditions within a population and planning appropriate, targeted and effective intervention strategies (Fairchild et al., 2018). The absence of published, peer-reviewed, national prevalence data may hinder the development of appropriate strategies for preventing and supporting psychologists experiencing burnout (Ben-Zur & Michael, 2007; BPS, 2020). Future research may benefit from capturing prevalence data in the UK as an essential step towards understanding and preventing burnout risk in psychologists in the UK healthcare workforce.

In other healthcare roles, such as GPs (Abdulla et al., 2011), doctors (Amoafo et al., 2015), and nurses (Gómez-Urquiza et al., 2017; Membrive-Jiménez et al., 2020) younger professionals are at a greater risk of burnout than

their older counterparts. Our findings were consistent with these reviews. As many eligible studies were cross-sectional, we cannot explain causation; however, we can use the Job Demands-Resources Model (Bakker & Demerouti., 2007) to offer one hypothesis for these findings. Younger psychologists may be more likely to be experiencing life transitions, which may place greater demands on their resources (Blair., 2000). Some transitional stages may disproportionately affect females, particularly childcare responsibilities accounting somewhat for the gender differences our review observed. Though results were more mixed, female psychologists, much like their other multidisciplinary colleagues (Hoff & Lee., 2021), appear at greater risk for burnout than their male colleagues. Psychologists across the western world work in a wide variety of different settings. Whilst this review found evidence for the role of age and gender in psychological burnout, it requires a more nuanced investigation. For example, findings were reported in binary gender categories, not capturing the experience of the increasing number of psychologists who identify as non-binary (Richards & Barrett., 2020). Future research could aim to explore less binary concepts of gender and interactions between these factors and others, such as age and workplace.

Many of the occupational factors linked to higher levels of burnout in psychologists were consistent with the research relating to other healthcare professionals, particularly high workloads, long hours, lacking resources and high demand (Amoafo et al ., 2015; O'Connor et al., 2018 Patel et al., 2018). Two subthemes appeared to be more specific to psychologists; professional culture and the emotional intensity and impact of the work.

Psychology is a highly competitive field. From gaining pre-training

experience securing a place on a training programme (Scior et al., 2014; Callahan et al., 2018), completing rigorous training academic requirements (Pakenham & Stafford-Brown, 2012) and working in complex systems (Kannampallil et al., 2011), psychologists experience pressure throughout their professional journeys (Cushway and Tyler., 1996). The stressors are well documented. Given this picture of the psychology field as highly ambitious and competitive (Ragavan., 2018), it is unsurprising that this review found that perceived and experienced pressure was a significant factor in psychologists' experience of burnout. There was also a clear link between engaging with clients with high levels of distress and higher levels of burnout, with a particular focus on the negative impact this had on psychologists' ability to manage personal relationships at home.

These findings suggest that for some psychologists, the very nature of their work can be a significant risk factor in the development of burnout. As such, interventions and strategies for burnout prevention could benefit from more systemic approaches, targeting the psychology profession and organisations which employ them (Zinsstag et al., 2011). Research tends to focus on exploring the negative impacts of working with high levels of distress, such as burnout; however (Sodeke-Gregson et al ., 2013), we must be careful to acknowledge that, as evidenced by our findings, not all psychologists experience burnout. Exploring the experience of psychologists who experience positive work-related well-being could allow researchers to consider what we can learn from psychologists who are not experiencing burnout. This exploration could be beneficial in understanding how to best support the workforce's needs.

Review findings supported evidence demonstrating a multidirectional

relationship between burnout and personal experiences (Asanta et al., 2019; De Hert., 2020), with one participant referring to the interaction as 'the perfect storm' (Turnbull & Rhodes., 2021, p. 55). Use of humour, beliefs about ethical practice, and mindfulness were all suggested to be linked to burnout levels; however, there was not enough data to provide conclusive links in this review. Far more exploration of these is required to understand their role in developing burnout.

Social support appears to have positive and negative impacts on psychologists' experience of burnout. Interpersonal relationships have long been acknowledged as important sources of social support that can promote healthcare staff's well-being and mental health (Stubbs & Achat., 2022). Psychologists perceived positive interpersonal relationships with supervisors as a mediating factor in developing burnout. Other healthcare professionals have reported similar findings (Dyrbye & Shanafelt, 2016; Ruisoto. 2021). Much like their healthcare colleagues, psychologists highlighted interpersonal conflict, with family, and workplace supervisors, as negatively contributing to their experience of well-being at work (Lloyd et al., 2002). This is an important finding as supervision is positioned as a tool to ensure the efficacy and safety of psychologists' work and safeguard their emotional well-being (Falender, 2018). Ensuring that high-quality supervision is available for psychologists should be a priority for employers. However, caution must be given to supervision limitations as effective prevention, as evidence suggests supervisory experiences improve disengagement but do not reduce emotional exhaustion (Johnson et al., 2021). Thus, an integrative approach to burnout, encompassing a range of support, is likely to be required.

Expansion of Knowledge Base and Clinical Implications

In line with McCormack et al.'s (2018) findings concerning allied psychological professions, this review suggests that emotional exhaustion is salient in the experience of burnout for trainee and qualified psychologists. To the researcher's knowledge, it is the first review to report findings related explicitly to burnout in this population. By focusing on professional psychologists, the researchers have identified profession-specific experiences, such as the emotional intensity of their work and the culture in the psychology profession, which may contribute to emotional exhaustion in psychologists. This enables the researcher to make profession-specific recommendations to support the needs of professional psychologists.

Given that there are arguments for both individual responsibility (West et al., 2018) and corporate social responsibility (Liu et al., 2023) in preventing and managing employee burnout, findings indicate that psychologists and those who employ psychologists may benefit from attending to early signs of fatigue, apathy and emotional disengagement. Interventions for emotional exhaustion in front-line healthcare staff should focus on identifying causation factors and supporting the reduction of symptoms (McFarland & Hlubocky., 2021). Employers and individuals may wish to consider mindfulness-based interventions, which have positively impacted emotional exhaustion in the general workplace population (Hülsheger et al., 2013) and specifically with healthcare staff (Kriakous et al., 2021).

Findings also suggest that younger and less experienced psychologists may be at an increased risk for developing burnout. Therefore, it may benefit psychologists and employers to increase support for and monitoring of

psychologists' emotional well-being in the pre-qualification and newly qualified stages. This could be achieved through increased frequency of supervision, supportive peer spaces for newly qualified psychologists and clear and accessible pathways for supporting well-being.

Interpersonal conflict and team dynamics may also contribute to psychologists' experience of burnout. We must consider this in light of the knowledge that psychologists are often positioned to mediate team conflict via reflective practice (Heneghan et al., 2014), which may become an interpersonal workplace stressor. Again, research exploring the impact of team dynamics specifically on psychologists would be of benefit; however, employers could consider outsourcing reflective practice spaces from psychologists outside of their team to help minimise the emotional impact of this role.

Limitations and Future Research

Grey literature was excluded to support the rigour of the review; however, many psychologists in training conduct research regarding psychologists' experience with burnout but do not go on to publish their findings. Future reviews may wish to include grey literature and adopt a rigorous quality assessment process to exclude papers of insufficient quality before analysis, widening the potential pool of eligible studies.

Consideration must be given to the integrated approach to the narrative synthesis. The researchers followed JBI's advice to qualitise the quantitative data as codifying quantitative data produces fewer errors than attributing numerating qualitative data (Stern et al., 2020). Despite this, researchers acknowledge that qualitising data is a relatively under-researched area and rely

heavily on the researchers' ability to consistently apply their research principles to the conversion process, which will likely impact the data analysis and interpretation (Dixon-Woods et al., 2005). Additionally, the findings are based only on the data reported by the authors of the included papers (Aveyard., 2018). For the findings drawn from qualitative studies, the researcher's beliefs about the data and phenomenon of interest will have impacted the interpretation of the findings (Smith et al., 2021).

Despite many burnout measures having satisfactory validity and reliability (Kristensen et al., 2005), different tools are likely to report varying levels of burnout depending on the dimensions they measure. The lack of homogeneity of burnout measures in this review means that caution must be employed when considering generalising the findings of this review across populations, settings, and countries. Future reviews into burnout research may benefit from considering the most widely used burnout tool in research and clinical settings in their country of origin to support the generalisability of findings. This could be incorporated into their inclusion and exclusion criteria.

Conclusion

This review was the first to explore the prevalence and factors related to burnout in qualified psychologists. Several factors are associated with the development of burnout, many of which are consistent with burnout for their healthcare colleagues; psychologists may experience additional risk factors due to the emotional intensity and impact of their work and the culture of the psychology profession. Psychologists may experience moderate to high levels of emotional exhaustion burnout linked to their occupation; however, providing

an accurate overall prevalence is challenging due to vast differences in how prevalence data is collected and reported.

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Appendices

Appendix A: PRISMA Checklist With Locations

(Adapted from Page et al., 2021)

Section and Topic	Item #	Checklist item	Location where the item is reported
TITLE			
Title	1	Identify the report as a literature review.	Title Sheet
ABSTRACT			
Abstract	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings. See the PRISMA 2020 for Abstracts checklist for the complete list.	Abstract Section
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge, i.e., what is already known about your topic.	Provided in the background literature review
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	Provided in the reeview aims and objectives and methods.
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses with study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	Provided in the method sections
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	Methods sections and appendices
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Methods and Appendices
Selection process	8	State the process for selecting studies (i.e., screening, eligibility). Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	Covered in the methods section

Section and Topic	Item #	Checklist item	Location where the item is reported
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	Covered in methods and findings
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Methods
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Methods and Prisma flow chart
Study characteristics	17	Cite each included study and present its characteristics (e.g., study size, PICOS, follow-up period).	Summaries in key information table
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Presented in the table and in the quality assessment summary paragraph
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots. Clearly represent which studies have identified which findings, and offer transparency around the use of outcomes measures, country of origin, and training background of participants	Covered in methods and discussion
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Discussion
	23b	Discuss any limitations of the evidence included in the review.	Limitations and future research
	23c	Discuss any limitations of the review processes used.	Limitations and future research
	23d	Discuss implications of the results for practice, policy, and future research.	Limitations and future research
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	Review not registered, not a requirement at time of understaking the review
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	Review not registered, not a requirement at time of understaking the review
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	Review not registered, not a requirement at time of understaking the review

Section and Topic	Item #	Checklist item	Location where the item is reported
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	N/A for Dclin
Competing interests	26	Declare any competing interests of review authors.	N/A for Dclin
Availability of data, code, and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	Full titles and authors of papers are provided

Appendix B: Full Search Terms

	Database		
Search Terms	MEDLINE	PsychInfo	Webb of Science
	1 ("burnout" and "psychologist*" and (stress* or "emotional exhaustion*" or pressure or coping or manage* or "well-being" or "mental health" or "work related stress" or "compassion Fatigue"))	1 ("burnout" and "psychologist*" and (stress* or "emotional exhaustion*" or pressure or coping or manage* or "well-being" or "mental health" or "work related stress" or "compassion Fatigue")).	1 "burnout"
	2 Limit 1 to'll adult (19 plus years)	2 limit 1 to "300 adulthood <age 18 yrs and older>"	2 Psycholigist*
	3 Burnout, Psychological/*	3 exp Occupational Stress/*	3 (stress* OR "emotional exhaustion*" OR pressure OR coping OR manage* OR "well-being" OR "mental health" OR "work related stress" OR "compassion Fatigue")

	4 Occupational Stress/*	4 exp Psychologists/*	4 1, 2 and 3
	5 3 and 4	5 3 and 4	
	6 1 or 5	6 1 or 5	
	7 Limit 6 to "all adult (19 plus years)"	7 Limit 6 to "300 adulthood <age 18 yrs and older>"	
Results			
/* Database specific MeSH terms			

Appendix C: Sample of the Extraction Table

Part 1

Reference	Paper ID	Country	Aim	Design	Participants	Use of Burnout
Ackerley, G. D., Burnell, J., Holder, D. C., & Kurdek, L. A. (1988). Burnout among licensed psychologists. Professional psychology: Research and practice, 19(6), 624.	#1	USA	To examine the level of burnout in a national sample of licensed psychologists & to examine the correlates of burnout.	Quantitative. Descriptive cross-sectional studies (Prevelance Study) Postal Surveys Pearsons Correlations & ANOVA , MAOVA & Multiple regression analysis	562 Dcotoral Level, Licenced Psychologists. 27% were female. 73% were Male 64% (360) Clinical Psychologists 20% (112) Counselling Psychologists 13% Other	Dependent Variable - Measuring the presence and level of. It's not a pre-requisit of taking part
Allwood, C. M., Geisler, M., & Buratti, S. (2022). The relationship between personality, work, and personal factors to burnout among clinical psychologists: exploring gender differences in Sweden. *Counselling Psychology Quarterly*, *35*(2), 324-343	#2	[illegible]	To investigate the effects of gender, personality, Job demands, affective work rumination and personal-to-work conflict on burnout amongths clinical public health psychologists in [illegible]	Quantitative. Descriptive cross-sectional studies (Prevelance Study) Web-based survey	828 Clinical Public Health Psychologists 78 % women, mean age = 43 years, SD age = 11 years. Representtitive of the swedish psychologist [illegible]	Burnout measured as an [illegible]

H	I	J	K	L	M
Definition of Burnout	**Dimensions of Burnout Measured**	**Burnout Measurement Tools**	**Prevelance, Causes or Factor**	**Findings / Clinical Relevance**	**JBI Checklist**
Consider Burnout to be related to a social interaction between helper and recipient (Maslach, 1982b), the consequence of high levels of job stress, personal frustration, and inadequate coping skills (Paine, 1982).	Emotional exhaustion, depersonalization, and reduced personal accomplishment	**Maslach Burnout Inventory (MBI) & The Psychologist's Burnout Inventory (PBI)** (Developed by the researchers) - A Fifteen item survey in a 7-point likert scale format identical to that of the MBI to assess factors that have been speculated to be related to burnout in psychologists.	Prevelance	**1)** Average levels of emotional exhaustion, depersonalisation and personal accomplishment for psychologist significantly higher than mental health workers (as detailed by the MBI). **2)** 39.9% of thepsychologists were experiencing high levels of emotional exhaustion, 34.3% were also experiencing high levels of depersonalization. Only 0.9% of this sample were in the range associated with high levels of burnout linked to personal accomplishment. **3)** Younger psychologists expereinces highed emotional exhaustion compared to older colleauges. **4)** The three dimensions of burnout were not significantly linked to gender, relationship status, theoretical orientation, and involvement in personal therapy. **5)** Psychologists in private practice experienced less emotional exhaustion, less depersonalization, and more personal accomplishment than those in the public sector. **6)** Number of years in direct service negatively correlated with emotional exhaustion and depersonalization	Prevelance Checklist
Do not provide a clear definition of Burnout, however they highlight		Exhaustion was measured by the validated Swedish version of the **Shirom-Melamed Burnout Questionnaire (SMBQ)** The scale has 22 items and includes four subscales: Physical exhaustion, Listlessness, Tension, and Cognitive weariness. Each item is rated on a seven-point scale ranging from 1"Almost never" to	Prevelance & Factors	**1)** 21.6 % of psychologists scored above the SMBQ cut off score for sever burnout. **2)** Significant negative relation between relational self-construal and exhaustion, suggesting that sociality may act as a resource protecting against exhaustion. **3)** Personal-to-work conflict and brooding had the same level of assiciation to exhaustion. Their results supported a strong relationshios between personailty variable and exhaustion as a dimension of burnout. Suggesting the need for further research into personalilty variables and burnout. **4)** Brooding and affective work rumination were noticeably related to disengagement. **5)** Job Demands (emotional demands and, especially, role conflict) were clearly related to disengagement .	

Appendix D: JBI Checklist for ACS

Item	Question
1	Were the criteria for inclusion in the sample clearly defined?
2	Were the study subjects and the setting described in detail?
3	Was the exposure measured in a valid and reliable way?
4	Were objective, standard criteria used for measurement of the condition?
5	Were confounding factors identified?
6	Were strategies to deal with confounding factors stated?
7	Were the outcomes measured in a valid and reliable way?
8	Was appropriate statistical analysis used?

Comments:

Response Options: Yes, No, Unclear or Not Applicable

Appendix E: JBI Checklist for Qualitative Research

Item	Question
1	Is there congruity between the stated philosophical perspective and the research methodology?
2	Is there congruity between the research methodology and the research question or objectives?
3	Is there congruity between the research methodology and the methods used to collect data?
4	Is there congruity between the research methodology and the representation and analysis of data?
5	Is there congruity between the research methodology and the interpretation of results?
6	Is there a statement locating the researcher culturally or theoretically?
7	Is the influence of the researcher on the research, and vice- versa, addressed?
8	Are participants, and their voices, adequately represented?
9	Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?
10	Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

Comments:

Response Options: Yes, No, Unclear or Not Applicable

Appendix F: Summary of Thematic Synthesis Theme Development for Quantitative Data

Analytical Theme	Descriptive Theme	Example Codes	Example Quotes
Presence of Burnout	Burnout Outcome Measures	Lower than standard norms, higher than standard norms, sever/ high burnout, mild burnout, moderate burnout, high emotional exhaustion, high depersonalisation, low personal accomplishment.	'Mean emotional exhaustion (EE), depersonalisation (DP) and personal accomplishment (PA) were significantly higher than MBI standards for mental health workers', '49.2% of participants scored in the high burnout range'
Demographic Characteristics	Age and Gender	Women, men, older psychologists, younger psychologists, age.	'Younger psychologists scored higher on EE than older peers', '…correlations indicated that younger age was related to higher burnout.', 'Females had significantly higher personal burnout.'
Occupational Experiences	Work Setting, Years' Experience and the Impact of the Work	Early career psychologists, newly qualified psychologists, private practice, agency psychologists, job satisfaction, caseload, relationships with colleges, job demands, role-conflict.	'Role conflict was positively correlated with disengagement.', 'Psychologists in private practice experienced less emotional exhaustion, less depersonalisation, and more personal accomplishment'
Personal Resources	Humour, Beliefs about Burnout and Coping	Self-defeating humour, self-enhancing humour, positives associated with humour, believe burnout	'Unrelenting Standards Early Maladaptive Schemas were most highly endorsed by both the low and high burnout group',

		is unethical, maladaptive coping modes, early maladaptive schema, self-sacrificing	'Self-defeating humour ($\beta = .32$, $p < .001$) had the biggest negative impact on psychologist's burnout'
Social Support Networks	Talking to Family and Friends	Less social support, work-family conflict, talking to friends, discussing frustration with family.	'Discussing work frustrations with family, friends or colleagues positively correlated with overall burnout', 'greater burnout was associated with less social support'

SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

Empirical Research Project

Well-being and Clinical Psychology Training: An exploration of clinical psychologist's learning experiences through clinical training and the impact post-qualification.

Trainee Name: **Amy Claire Peters**

Primary Research Supervisor: **Dr Cordet Smart**

Secondary Research Supervisor: **Dr Rachel Handley**

Target Journal: **British Journal of Clinical Psychology**

Word Count: **11,773 (excluding abstract)**

Submitted in partial fulfilment of requirements for the Doctorate Degree in Clinical Psychology, University of Exeter

Abstract

Background: Clinical psychologists (CPs) can experience poor well-being due to their professional demands (Bettney., 2017). Clinical psychology training programmes must support CPs in developing their ability to manage their well-being (Myers et al., 2012 BPS., 2017); however, to the researcher's knowledge, no research explores CPs' experiences of learning about well-being through training. Thus, the current study aims to address this gap and explore the impact of this learning post-qualification.

Methods: Twelve recently qualified clinical psychologists participated in semi-structured interviews exploring their well-being-related learning experiences during training. Transcripts were analysed using interpretive phenomenological analysis (IPA) to generate key themes.

Findings and Discussion: Four key themes were identified across participants' experiences. These were: implicit messages about well-being, well-being is not prioritised, connection maintains well-being and inadequate preparation for post-qualification challenges. Findings highlight the importance of organisational culture and implicit communication in CPs' learning experiences.

Clinical Implications: Course providers should carefully attend to *what* and *how* messages about well-being are communicated to trainee CPs during training to maximise opportunities to prepare CPs to take a sustainable approach to their well-being.

Keywords: *Well-being, Clinical Psychology, Clinical Psychologists, Training, Meaning Making*

Introduction

Clinical psychologists (CPs) are susceptible to poor well-being due to work-related stressors, including large caseloads, insufficient staffing, and the emotional impact of working with clients experiencing emotional distress (Myers et al., 2012; Bettney., 2017). CP's well-being warrants investigation for several reasons. Firstly, it can have profound psychological consequences, including burnout, depression, and anxiety (Jones & Thompson., 2017; McCormack., 2018; Richardson et al., 2020). There may also be adverse consequences for patient safety, with poor well-being linked to increased clinical errors (Hall et al., 2016). Lastly, many CPs are leaving the NHS workforce and stating work-related stressors, unsustainable working conditions and poor work-life balance as reasons for leaving (Ahmed et al., 2022; Shemtob et al., 2022). With a 14% vacancy rate for NHS CP posts (HEE., 2021; Deakin, 2022), well-being presents a significant concern in ensuring the NHS is sufficiently staffed to meet the ever-increasing demand for services (Baker., 2020; HEE., 2021).

Given the significant impact of staff well-being and the emotional impacts of COVID-19 on healthcare workers, it is unsurprising that the NHS has faced increased pressure to support the well-being of their workforce (The Kings Fund., 2018; Clarkson et al., 2023). Individual clinicians are also being encouraged to proactively manage their well-being (Bettney., 2017; Walker., 2017). Historically, research on CP well-being focused on identifying work-related stressors and developing interventions to improve well-being (Cushway, 1992; Hannigan et al., 2004; Pakenham & Stafford-Brown., 2012; Pakenham., 2015). CPs complete a rigorous doctoral training programme that presents opportunities for varied and immersive learning in various areas, including

personal and professional development, such as well-being (British Psychological Society, BPS., 2017). Currently, no research explores CP's well-being-related learning during this period. Thus, the current addresses this gap by exploring CP's experiences of learning about well-being during training and the impact of this learning post-qualification.

Defining Well-being

Staff well-being has become a key consideration in occupational health due to the recognition of its relationship to workplace productivity and staff retention (Simons & Baldwin., 2021). There is a lack of consensus on the definition of well-being (Forgeard et al., 2011; Dodge et al., 2012; Simons & Baldwin., 2012); however, it is generally accepted that it is a state in which an individual experiences positive feelings, growth, and a sense that they can meet their potential in a given environment (Simons & Baldwin., 2021). It encompasses biological, social, and psychological factors such as demands and resources (Dodge et al., 2012) and can fluctuate over time. An integral concept of well-being is a desire to achieve equilibrium or stasis (Cummins., 2010).

A historical review of occupational well-being models is provided by Schmidt and colleagues (2019); however, the Job-Demands Resource Model (J-DRM) is often cited as a helpful way to operationalise workplace well-being in healthcare settings(Bauer et al., 2014). The J-DRM suggests that occupational experiences can be divided into two categories. The first, Job demands, refers to the aspects of one's role that require sustained effort (such as high workloads) and are associated with biological, psychological and social costs (Bakker and Demerouti, 2017). Personal resources are the second category,

which refers to aspects of the job that help to support one's ability to reach work-related goals and improve their occupational experience. Job and personal resources (such as relationships with colleagues and optimism) work to reduce the costs associated with job demands and stimulate personal growth (Demerouti et al., 2001; Xanthopoulou et al., 2009). Although the J-DRM receives criticism for lack of distinction between processes, such as what constitutes a demand or resource or the role of internal motivation (Taris & Schaufeli., 2018), the model provides a robust conceptualisation of well-being for occupational research (Schaufeli, 2017).

Well-being in Clinical Psychologists

Historically, psychologists neglect the importance of developing and maintaining a balance between caring for others and the self (Wise et al., 2012). This is reflected in research indicating that CPs are at high risk of experiencing work-related distress and burnout (Lee et al., 2011; Bettney., 2017). During training, competing clinical, research, and academic demands, alongside the anxiety caused by constant evaluation, have been consistently shown to impact trainee CP's well-being negatively (Cushway., 1992; Hannigan et al., 2004; Pakenham & Stafford-Brown, 2012; Pakneham., 2015).

Trainee CPs must inevitably transition from students to qualified practitioners, which can be a challenging period for the well-being of healthcare professionals, including CPs (Van Den Broek et al., 2020; Levinson et al., 2021). According to Melesis Transition Theory (Meleis et al., 2010), healthcare workers may experience disconnection from previous social or organisational support structures, loss of reference points, new responsibilities, and increased autonomy when transitioning to qualified practice. Understanding the potentially

stressful experience of transitioning from a trainee to a qualified CP is important in understanding how the well-being of CPs may change over time and identifying periods that may pose a more significant threat to CP's well-being. It may also help to identify opportunities for meaningful intervention, which may be beneficial targets for explorative research (Levinson et al., 2021).

Once qualified, CPs continue to experience stressors now relating to job demands, large caseloads, and working in isolation (Myers et al., 2012; Bettney., 2017). Supporting clients experiencing emotional distress can lead to the experience of vicarious trauma, the negative effects of which are well documented (Lim et al., 2010; Makadia et al., 2017). Research has highlighted that many psychologists are experiencing burnout and report significant challenges in maintaining work-life balance (McCormack et al., 2018). Maintaining well-being and engaging in self-care can help to reduce the risk of burnout in CPs (Rupert & Dorocaik., 2019). The current provision of well-being learning opportunities on DClinPsy courses may unwittingly contribute to a professional culture in which psychologists struggle to connect with a need to prioritise their well-being (Wise et al., 2012). With recently qualified CPs at continued risk of poor well-being, we must fully understand the role of this highly formative clinical training period (BPS., 2019) in preparing CPs to manage their well-being throughout their careers. Maintaining well-being and engaging in self-care can help to reduce the risk of burnout in CPs (Rupert & Dorocaik., 2019). The current provision of well-being learning opportunities on DClinPsy courses may unwittingly contribute to a professional culture in which psychologists struggle to connect with a need to prioritise their well-being (Wise et al., 2012).

Upon completing the doctorate, many CPs continue to work in the NHS (Odusanya et al., 2018). Most recent figures published in 2019 showed that 20,000 psychological professionals worked within the NHS, with CPs accounting for over 42% of the psychological profession's workforce (HEE., 2021). The demand for psychologists is increasing, with plans to train and recruit 2,520 additional psychologists into the workforce by 2024 (HEE., 2021). Though poor well-being has become an increasing concern for CPs throughout their careers, those at an early career stage or in training may be particularly susceptible (Pakenham & Stafford-Brown, 2012; Rose et al., 2019). To support the expansion of the CP workforce, it is fundamentally important that we understand more about CPs' experience of learning about well-being in the early stages of their careers, including training and the transition into post-qualification.

Clinical Psychology Training, Learning, and Well-being

To become a CP in the UK, individuals complete a three-year Doctorate in Clinical Psychology Programme (DClinPsy) in one of the 30 approved training institutions. The training follows a competency-based training model to support the development of doctoral standard academic, clinical and research skills (Kenkel & Peterson., 2010). Trainees are also required to meet an appropriate level of personal and professional development (Nel et al., 2012).

The DClinPsy is a post-graduate adult learning experience which utilises formal and informal experiential work-based learning (Costley & Lester., 2012; Nisbet et al., 2013). Learning occurs through attendance at clinical placements, formal learning (e.g., university lectures and workshops) (Choi and Jacobs, 2011), and independent learning through completing a research thesis (Nel et

al., 2012). In preparing CPs for NHS careers, training programmes must provide structured opportunities for strategy development for well-being (Gockel., 2010; Pakenham & Stafford-Brown, 2012). Of the nine core competencies and 71 sub-competencies for CPs in training, only two sub-competencies recognise the importance of trainee well-being. The BPS does not provide specific directions on how to support trainee CPs to meet these well-being-related competencies (BPS., 2017). As such, CP's learning experiences will likely vary significantly across DClinPsy courses. Literature searches did not reveal any research exploring what CPs learn about well-being during training (BPS., 2017); however, research does suggest that training programmes do not adequately support trainee CPs to develop strategies for well-being maintenance (Lambert & Simon, 2008; Myers et al., 2012; Brettney., 2017). Despite there being a role for DClinPsy courses in supporting CPs to learn about well-being, the paucity of research exploring the learning experiences of CPs presents a significant gap in the research understanding of the impact of training on CP's well-being throughout their careers.

Individuals' learning experiences are shaped by their pre-conceived assumptions, knowledge and experiences, which are heavily influenced by their experience of the world. Through learning, individuals attempt to understand and give meaning to their experiences (Billett, 2008; Nevalainen et al., 2018). During the DClinPsy, each trainee CP experiences individualised learning; however, for NHS staff, Organisational culture (OC) can enhance or inhibit their learning experience (Davies & Nutley., 2000). OC refers to ways of thinking, feeling, and behaving shared by individuals in a healthcare organisation (Mannion & Davies., 2018). Culture is a fundamental part of the stories and

narratives organisations, teams, and subsequently, individuals learn to hold about why things are done in a certain way (Simpson et al., 2019). It provides individuals with guidance on how they are expected to think, feel and behave in relation to a range of topics, such as well-being (Nanayakkara & Wilkinson., 2022).

According to Schein (1990), there are three levels of OC, which help to demonstrate the potential impact of OC on CP's experiences of learning about well-being. Artefacts are the shallowest indicator of OC; they refer to the visible indicators of culture, such as dress codes, banding or role titles, and office layouts (Davies 2002; Mannion & Davies., 2018). Organisational values, mission statements, and written communications are all examples of espoused values. These are deeper aspects of OC that would create some noticeable change to overall OC in an organisation such as the NHS (Scott et al., 2003). The deepest and arguably most important aspect of OC, according to Schein (1990), comes from underlying beliefs and assumptions; these reflect individually held assumptions about how employees should perform, interact with others, and conduct themselves. These are the strongest indicator of what an organisation is like; they are often held by the individual, hard to access, and even more challenging to influence (Al Saifi., 2015). These aspects of OC can significantly impact the overall content and process of the learning experience for healthcare workers (Davis & Nutley., 2000).

During their training, CPs are uniquely positioned as they experience their learning within the context of two large organisations, the NHS and their host university. The NHS culture for frontline staff has long been characterised by the expectation to start work early, finish late, and to subjugate one's needs

for the needs of the patients (Mackenzie., 1995). In addition, emotional stoicism, or the tendency to endure hardship without complaint, or external expression of the distress caused, is highly valued in the NHS culture (McCarthy et al., 2020). The OC relating to senior management in UK universities has received some research attention (O'Connor., 2011); however, the review of the evidence provided little research exploring the student experience of OC at UK universities. There are several reported similarities in the culture across the NHS and Universities in the UK; for example, due to an increase in the use of national frameworks, focus on auditing, and producing outcome and performance data, both incorporate aspects of a hierarchical culture (Jacobs et al., 2013). As OC is such a nuanced element of organisational life, there are likely differences or conflicts in the underlying beliefs and assumptions held by individuals across these organisations (Sagiv & Schwartz., 2007), which CPs will experience in their well-being learning journey. Adapting to and integrating the experience of university and NHS cultures is not dissimilar to the notion of acculturation (Thacker et al., 2022). Acculturation refers to the process in which people adapt to the dominant culture in a specific environment while retaining some of their cultural values and beliefs. Though this is often used in relation to the experiences of people from multicultural backgrounds, it is helpful to consider this process concerning the learning experiences of CPs during clinical training.

OC is both an individual and group phenomenon. The individual aspect of OC, which is concerned with the sense-making of the individual in relation to aspects of culture, such as the impact of underlying assumptions and beliefs, is often overlooked but is, in fact, imperative in the manifestation and maintenance

of OC (Harris., 1994; Dougherty & Smythe., 2004). Based on this, it is reasonable to suggest that an exploration of CP's learning experiences relating to well-being, and the OC context in which they take place, could be beneficial in further understanding CPs' learning and ongoing maintenance of their well-being. Moreover, understanding the culture around well-being is essential in creating change to unhelpful aspects of OC (Scott et al., 2003).

Interpretive Phenomenological Analysis

Well-being is arguably an individual learning experience which occurs in a wider cultural context. For CPs, the underlying beliefs and behaviours they are exposed to in their OC and subcultures will likely influence their sense-making experiences in the learning process (Mahler., 1997). In their review of best practices for DClinPsy learning, Nel and colleagues (2012) argue that a qualitative approach to research utilising semi-structured interviews is required to obtain a more in-depth understanding of CPs' lived experiences of learning during clinical training.

IPA is a qualitative analysis method that, by focusing on an individual's sense–making, provides an ideographic approach to exploring specific events or experiences (Alase., 2017). IPA allows researchers to present interpretive findings which may be transferable to an appropriately homogenous group of CPs in the UK (Smith et al., 2022). Therefore, IPA is an appropriate method of analysis for the proposed research as it allows the researcher to draw out the ideographic learning experience related to well-being, including consideration of underlying beliefs and assumptions. Simultaneously, it allows for consideration of the broader cultural impact on CPs sense-making experiences (Smith et al., 2022).

The Rationale for the Current Research

This brief review of the literature illustrates that CPs are highly trained and highly-skilled assets which are critical in the composition of the psychological professions workforce and delivery of NHS services. Despite a vast body of research detailing CP's experiences of poor well-being, and the adverse consequences of this, there is an absence of research which explores what and how UK-trained CPs learn about well-being through training. This research aims to address this gap by exploring the well-being learning experiences of CPs during training and the subsequent impact of this learning on their post-qualification experiences.

This exploration may have several benefits. Firstly, it expands the current research field beyond identifying work-related stressors and the subjective well-being experience and into the somewhat overlooked area of well-being learning experiences. Moreover, it shines a light on the lived experience of CPs in learning about well-being, with a particular emphasis on what it is like to experience this learning in the context of the beliefs and assumptions held by organisations such as the NHS and DClinPsy host universities.

The research may enable researchers to make recommendations to course providers to ensure that training programmes maximise the learning opportunity to prepare CPs to manage their well-being throughout their NHS careers sustainably. In addition, understanding the impacts on their early post-qualification experiences of well-being would be beneficial in understanding how this learning is carried into their post-qualification experiences and provides similar opportunities for recommendations to NHS trusts supporting newly qualified CPs in their transition to qualified practice.

To achieve these aims, the researchers intend to answer the following research questions:

1. What are clinical psychologists' experiences of learning about well-being during training?
2. How does this learning impact clinical psychologists' experience of well-being post-qualification?

Method

Methodology

The researcher is aligned with a cultural relativist stance, which dictates that there is no one truth (Thomas & Yahix., 2016). The researchers believed that each CPs' sense-making would be based on their societal context and could change over time (Peat et al., 2018). An emic epistemology was selected to underpin the research, allowing the researchers to explore CPs' experiences of learning about well-being through the participant's perspectives, beliefs and lived experiences.

Ethical Approval

Ethical approval was granted by the University of Exeter Psychology Ethics Committee (Appendix A). Participation was voluntary. Participants were able to able to withdraw up to one month after their interview. After this time, participant data were anonymised, and the link document was destroyed.

Participants

Clinical Psychologists who graduated from a UK-based Doctorate in Clinical Psychology course in the last two years (between 2018 and 2020) were invited to participate. The BPS does not define the ‘newly qualified period for

CPs, so this time frame was chosen as it would capture newly qualified psychologists able to recall their training and newly qualified experiences in detail required for the study.

Recruitment

Participants were recruited via Facebook and Instagram using a research poster (Appendix B) posted in groups specifically for CPs or related to clinical psychology (Appendix C). Participants who expressed interest via email were sent the participant information sheet (Appendix D) and encouraged to email the researcher with any questions.

Participants completed a consent form (Appendix E) and a demographic questionnaire via Qualtrics (Appendix F). Demographic characteristics (age, gender, ethnicity and sexual orientation) were collected to enable comparison with national data. Many CPs work with their training course providers post-qualification. To ensure participants could express their experiences fully, they were not asked to report their training course; however, during transcription, researchers identified that each participant completed their training at a different training programme.

The interview was arranged via email, and the participants were sent a Zoom link to a secure virtual room. Twelve participants completed the interview; however, one participant's data was removed from the before analysis due to issues with the recording quality.

Table 1

Participant Characteristics

Participant ID	Age	Gender Identity	Ethnicity	Sexual Orientation
P1	26-34	Woman*	White – British *	Heterosexual
P2	18-25	Woman*	White – British *	Heterosexual
P3	26-34	Woman*	White – British *	Prefer not to say
P4	26-34	Woman*	White – British *	Heterosexual
P5	35-44	Woman*	White -Irish	Heterosexual
P6	26-34	Woman*	White – British *	Bisexual
P7	26-34	Woman*	White – British *	Heterosexual
P8	26-34	Woman*	White – British *	Heterosexual
P9	26-34	Woman*	White – British *	Heterosexual
P10	26-34	Woman*	White – British *	Heterosexual
P11	35-44	Woman*	Black / Black British/ Caribbean/ African	Heterosexual
P12	26-34	Woman*	White – British *	Heterosexual

**Including transgender woman*
** Including English/ Welsh/ N Irish and Scottish*
Grey indicated the participants whose data was removed

Design

The study utilised individual semi-structured interviews, and Interpretive Phenomenological Analysis (IPA) was used to analyse the data and generate themes related to the participant's meaning-making experiences.

Semi Structured Interviews

Interview Schedule

A semi-structured interview schedule (Appendix G) was developed in four stages:

1. Existing literature was reviewed alongside the research questions, and questions were drafted.
2. The draft schedule was shared with the research team, a senior research associate at an independent university, and a clinical psychologist and academic tutor on a clinical psychology doctorate programme.
3. Edits, including the addition of prompts (e.g., ‘could you say more about how you learned X?’) and making questions more specific to focus on the experience of well-being (e.g., can you tell me about your *well-being* journey as a CP? were made to improve the schedule.
4. A pilot interview was completed with a newly qualified CP with less than one year of post-qualification experience. Minor amendments were made to improve flow and generate prompts (e.g., asking participants to consider different types of learning, such as formal, informal, etc.).

Procedure

Participants joined the interview using the zoom link provided. Before

starting the audio and video recording, participants were reminded of the following:

1. The research aims and given another opportunity to ask questions.
2. Their right to choose not to respond to any question without providing a reason and to stop the interview at any time without reason.
3. The removal of identifiable data at the transcription stage.

Interviews lasted approximately 60 minutes. At the end of the interview, the recording was stopped, and participants were given time to ask any final questions related to the project and debrief informally with the researcher. After the interview, participants were emailed the debrief sheet (Appendix H) and a £15 Amazon voucher.

Methods of Analysis

Consideration of Analysis Method

The researchers considered several methods of analysis consistent with the epistemological stance. Narrative analysis would have enabled the exploration of CP's meaning-making by exploring the language they used to construct their stories (Herman & Vervaeck., 2019), whilst discourse analysis would have supported an exploration through CPs language-in-use (Paltridge., 2021). Ultimately, IPA was chosen to explore well-being through CPs sense-making experiences (Smith et al., 2021), which felt best suited to exploring the emotional experience of learning about well-being (Colville et al., 2016), and the ideographic experience of beliefs and assumptions related to OC. An ideographic approach allows the researchers to explore how CPs' beliefs about well-being are shaped by their actions and experiences and how these continue

to shape future beliefs (Murphy, 2021). IPA is well suited to analysing small homogenous samples where participants have direct experience of the phenomena of interest (Peat et al., 2018), and is beneficial for analysing data with limited prior evidence in the field, as in this study (Creswell & Creswell, 2017).

IPA draws from three philosophical concepts*:* ideography, phenomenology and hermeneutics*.* Ideography is the cornerstone of IPA and underpins the researcher's epistemological stance. An ideographic approach to analysis enabled the researchers to shift the focus away from attempts to generalise the well-being experiences of CPs across the UK and instead champion the importance of understanding the individual lived experience (Smith., 2022). Ideography helped generate findings that may be transferable to the wider experience of some trainees but do not claim to prove or disprove the group's experience as a whole (Biggerstaff & Thompson., 2008).

Phenomenological principles were applied through the consideration of the CPs' perspective on their experiences learning about well-being, particularly their embodied experiences and how they make sense of their relationship to learning, well-being, clinical training and post-qualification (Miller et al., 2018); Love et al., 2020). Finally, the double hermeneutic, which refers to the impact researcher's attempts to make sense of the CPs own sense-making experiences has on the interpretation of data, was particularly important to consider in this research due to the researcher's status as a trainee clinical psychologist (Alase., 2017).

In IPA, reflexivity is the process through which the researcher reflects on their beliefs and experiences and considers their impact on the analysis

process. Clarity and transparency regarding the researcher's relationship to the data are crucial in IPA (Nizza et al., 2021). Engaging in personal reflexivity allowed the researcher to acknowledge their closeness to the phenomenon of interest, values and beliefs and how these may influence all stages of the research process.

IPA Process

Smith et al.'s (2021) guidance for conducting IPA was used to support the analysis process. The researcher used a free coding approach to immerse themselves in the participants' experiences and allow themselves to be presumptive, biased, creative, and unsystematic in their annotations (Larkin & Thompson., 2012). It allowed the researcher a space to reflect on their own biases, e.g. free coding an experience as 'harmful' to find that participant later described it as helpful.

Next, initial descriptive, linguistic and interpretive coding focused on experience and meaning-making was completed on a new copy of the transcript (Appendix I). Descriptive coding provided a summary of the content. Linguistic coding highlighted repetition or phrasing considered interesting to the researcher, e.g., repetitive use of the word detrimental was coded for P5. Interpretive coding was generated by noting the researcher's questions about the data; for example, 'is the participant expressing frustration here? Was coded tentatively as 'Frustration?'

These three levels of coding were summarised in experiential statements, which captured participants' emotional experience or meaning-making concerning their well-being experiences. Experiential statements (ES) were printed and pinned onto a board in random order (Appendix J). ES with

similar themes were grouped in one area of the board and labelled as emerging themes based on their connection, e.g., competing demands, constant assessment, and others' expectations. Personal experiential themes (PETs) were identified by grouping related emerging themes and naming the PET based on the shared connection across emerging themes. This process took place several times for each transcript. Each time a picture of the PETs and included ES was taken as a record before re-arranging the ES to consider alternative connections and groupings.

Once each transcript had been analysed, the overarching group experiential themes (GETs) across transcripts were identified using the same process as PETs (example provided in Appendix K). GETs were grouped based on their similarities; several different groupings were recorded and discussed with the researcher supervisors and colleagues in a University of Exeter IPA working group. The final decision on GETs grouping was based on the researcher's reflexive interpretation of the data.

Credibility

Data collection, analysis and interpretation were routinely discussed with supervisors and an IPA working group at Exeter University to support credibility. The analysis process and findings were presented at an academic conference at the University of Exeter which offered an opportunity for critical review from multiple perspectives. Transparency is imperative for the credibility of IPA research (Levitt et al., 2018). Examples of individual and group analysis are provided for transparency.

Reflexivity

Reflexivity is integral to the rigour and credibility of qualitative research (Smith., 2011a). To support this research, I engaged in an IPA working group (Smith et al., 2022), reflective journaling (Vicary et al., 2017), bracketing (Alase., 2017), and consultation (Miller et al., 2018). Provided below is an overview of how I used these methods to enhance reflexivity and rigour, along with examples of reflexivity in action.

IPA Working Group

I attended an Exeter University IPA working group facilitated by an experienced IPA researcher. A log of discussions from the IPA group can be found in Appendix L. When coding data, feedback from the group highlighted that the initial coding was heavily interpretive and missing descriptive content. In one instance, when discussing well-being, the participant said, '…actually, there is a lot of lip service to it' which I initially coded as 'Well-being Is insincere or tokenistic'. By sharing the transcript with the IPA group, I realised that I was focusing on a higher level of interpretation than was appropriate at this stage and that the missing descriptive coding was a necessary part of the interpretive process. As a result, the coding was changed to 'well-being can feel like lip-service with 'insincere?' as an additional code. This experience helped ensure that the original data was identifiable in all interpretive comments throughout the rest of the analysis process.

Reflective Journal

I kept a reflective journal where I explored my values, beliefs, feelings, and experiences concerning the research process (Vicary et al., 2017) (Appendix M). During an early interview, when describing their well-being

experience, one participant stopped describing their experience and said, ‘Well, you know how it is’. Using the journal to capture post-interview reflections, I became aware that the participant had assumed my experience as a trainee CP aligned with their own, inhibiting their sense-making description. From the next interview, I was attentive to conversational cues, which suggested the participant had assumed I had prior knowledge. I was careful to ask participants to expand on their experiences by adding an additional prompt to my interview schedule (‘‘I’m really interested in your experience. Please carry on if it feels comfortable.’). Doing this allowed me to feel I was giving participants adequate space to tell their stories and minimise assumptions about my pre-existing knowledge or training experience.

I also reflected on the interviews immediately after they took place. I regularly met with a fellow IPA researcher to discuss our reflective journal entries. Following my second interview, I noted, ‘[Participant] talked about how they were making sense of some of their experiences for the first time in the interview. Curious about why this might be?’ Together we wondered if this was the first opportunity the participant had to reflect on this aspect of training. As a result of this discussion, I noticed that within my sense-making experiences, I started to feel as though CPs were placing themselves in a vulnerable position by taking part and discussing their experiences for the first time. I also noticed increased pressure to ensure the research did justice to participants' experiences.

Consultation

I sought consultation from a CP in a local NHS trust. When developing the research questions, they highlighted the initial question, ‘What are clinical

psychologists' experiences of well-being during training? was too broad and may not capture participants' well-being learning experiences. Reflexive conversations with the CP revealed this lack of specificity was rooted in my knowledge of the DClinPsy training process and assumptions that others might consider learning about well-being to be part of the DClinPsy experience. This highlighted the importance of having reflexive spaces throughout the process to attempt to re-position myself as a researcher rather than a trainee CP. For example, when coding the data, I would ask myself, 'Is that your sense as a researcher or CP?'. Though I acknowledge that from an IPA perspective, I can not separate myself as a researcher from my lived experience, this was a useful way to balance informing and not biasing the analysis process.

Both research supervisors worked on DClinPsy courses which created complexity regarding credibility due to the closeness of the research team to the phenomenon of interest. This was evident in discussions about emerging themes where it was sometimes difficult to consider the role of responsibility for well-being from different perspectives. My research supervisors had alliances with course staff whilst I attempted to balance my lived experience as a trainee with my position as a researcher. There was also an imbalance of power between the supervisee and supervisor, making it very difficult to hold these differing views equally worthy of consideration. To contrast the internal perspectives held by the research team, I consulted with an IPA-focused Research Associate at an external university who had no affiliation with DClinPsy training. The consultant's unfamiliarity with the DClinPsy process was helpful in re-positioning the discussion to more of an outsider position. In doing so, I identified that the power imbalance between myself and my supervisor

made me feel I needed to prioritise my supervisor's views in the analysis and interpretation. As a result, the views of participants were getting lost. Reflexive discussions with an external critical perspective helped prioritise participants' voices. Reflexivity is explored further in the reflexive statement (Appendix O).

Findings

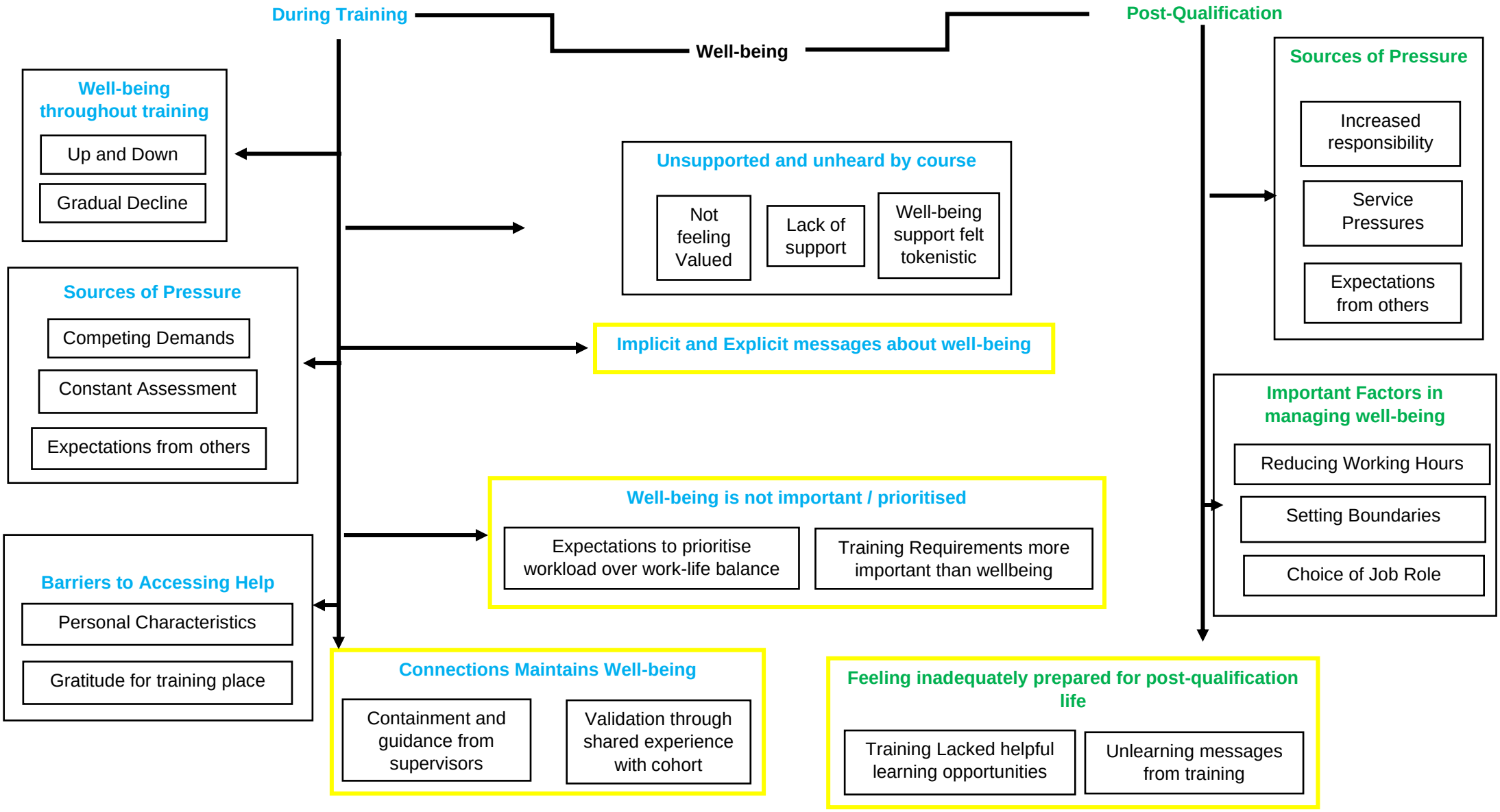
This study examined CPs experience of learning about well-being during training and how their learning about well-being impacted their post-qualification experiences. The overarching GETs are represented in Figure 2. GETs relating to participants' experiences during and after training highlight differences in the challenges to well-being faced in the trainee period compared to post-qualification. For example, participants experienced fluctuating pressures from competing academic, clinical and research demands. In contrast, once qualified participants experienced pressure aligned more with increased responsibility and specific service demands. The overarching GETs encompass participants' lived experience of well-being pre and post-qualification. Though they are not directly related to the research question, they have been included in Figure 2, as they highlight the qualitative differences in experience during and after training, which helps to understand how the learning during training was not always helpful.

The main learning experiences were identified in four GETs (highlighted in yellow in Figure 1). These were selected for discussion as they most directly address the research question relating to CPs' *learning experiences* related to well-being and post-qualification *impact*. How CPs learnt is encompassed in theme 1: implicit messages about well-being. Theme 2: well-being is not

prioritised, and theme 3, connection maintains well-being, provides insight into what was learned. Finally, theme 4: feeling inadequately prepared for post-qualification life, addresses the impact of learning. A breakdown of the number of contributing participants per theme is provided in Appendix P.

Figure 1

An overview of the emerging GETS organised by career stage, themes most relevant to the research questions are highlighted



Theme 1: Implicit Messages about Well-being

A key theme in participants' well-being-related learning experience brings attention to how participants learned. It captures the significance that participants placed, within their ideographic sense-making, on the unspoken aspects of communication. Several participants, including P4 and P11 (shown below), used the word ‘implicit’ in their sense-making accounts, whilst others, such as P7 described ‘unspoken rules’ that existed in the communication between themselves and others.

Participants seemed to experience and make sense of these communications and learning interactions as insidious, captured by descriptions of the learning as ‘powerful’ (P2) whilst also being ‘just really unhelpful’ (P9). At some point in their interview transcripts, all participants who contributed to this theme referred to an interaction with an individual as an interaction with ‘the course’. This highlighted a sense of ‘othering’ in how participants made sense of the relationship between trainees and course staff.

For some participants, these implicit messages communicated a belief that participants should not ‘complain’ about their well-being. There was a sense that participants felt an expectation from course staff to be grateful for their place on training.

> *P:4 ‘…yeah I think there's lots that the course has going for it in terms of the funding […], but I think it does perpetuate this “you should be grateful to be here” mentality. I really felt that that was an implicit message that you shouldn't complain too much 'cause we're doing you a favour by letting you be here and funding this course for you.’*

For some participants, this expectation or culture of gratitude seemed to cause frustration and was experienced as invalidating or in conflict with their lived experience of clinical training.

> *P:11 '…I felt there was an implicit kind of message if you have to get on with it, don't complain too much, and you are fortunate to be here; you're lucky to have your place on your course with all this funding. Just be quiet, get on with it and don't cause too much trouble.'*

This participants sense-making of expectation to be grateful appears to allude to a sense that these interactions discouraged them from speaking out about their well-being experiences. Another participant described how implicit messages were received about the acceptability of discussing well-being during training.

> *P3: '…I made a comment along the lines of "sometimes I find it really hard to separate the stuff that's happening for me in the room and the anxiety of being a new trainee",… and I remember the person that was leading the session being like ", yeah and that's why it's really important that you have the space to think about that", and then just moving very quickly on with something else. And I remember thinking, okay, so the message is we're not talking about that now that's too much deal with it, and then there was no check-in after.'*

Participants connected with this aspect of their experience by sharing specific examples of times they received implicit messages, quoting language, describing their emotional response to the experience, and offering more generalised learning or 'rules' about well-being that they took from the experience. Participants did not distinguish between the messages learned from

their academic versus their NHS experiences. Though this might reflect the interconnected nature of the clinical and academic aspects of training, it may also suggest a homogeneity in participants' experience of well-being cultures across the different organisational subcultures.

Theme 2: Well-being is Not a Priority

Most participants reported not feeling their well-being was a priority during clinical training. This deprioritisation appeared to be held by others, and participants learned through interpersonal verbal and behavioural interactions on training. This theme captured two distinct learned beliefs or assumptions about well-being as experienced by participants.

Training requirements are more important than your well-being.

Half of the participants interviewed felt that the words and behaviours of others communicated that the requirements of the DClinPsy were more important than their well-being.

> *P6: '…I think that message implies, you know, maybe in a very unspoken way, kind of, yeah, look after yourself. But first and foremost, make sure you do everything you need to do to finish the course and kind of everything else should get kicked to the side as long as you do the course.'*

There was also a learned sense from participants that others considered well-being to be a 'luxury' (P10) not a necessity.

> *P:4 '…I think that probably emphasized again that you're here to do a job that's what we're interested in is getting you through this course, and if*

we can do that with you as a relatively functioning human at the end of it, then that's great, but that's not essential.'

This quote suggests that some experienced a sense from course staff that there was a split between the needs of participants as employees and their emotional and well-being needs. Ultimately, this left them feeling that, from the course perspective, their emotional well-being was considered less important than their work responsibilities.

Another way in which participants described the de-prioritisation of well-being was through the learned belief that they should 'just keep pushing' through normal limits for well-being. This learning happened through means including discussions with 'the course', older cohorts, and local supervisors.

P4: '…I wonder if a bit of that came from the cohorts that went before us as well, not necessarily in a negative way that more in a this is shit, but you need to keep going, keep pushing on and we will support you if you can.'

In conversing with other training cohorts, there was a sense of participants experiencing the lack of consideration for wellbeing as an inevitability that they 'others have done it before me, and hundreds will get through it after me […]That's just the way it is' (P11).

Expectations to prioritise workload over work-life balance

Over half of the participants experienced learning that there was an expectation for them to work substantial additional unpaid hours on top of their contracted working hours. Many participants described learning that their

employer, in this case, the NHS, expected them to work additional hours to complete their job demands.

> *P:7 '…we had a very long reading list after every lecture.[…] That in itself sets an expectation as to what you think people are going to be able to achieve or how much time you think they should be spending in work on top of the 9-5 day. Because I suppose if your 9-5 day is attending that lecture, when do they suggest that you complete that reading?'*

Some participants felt that there was no way to complete the course requirements without working over their contracted hours and described feeling pressured to complete their work at any cost.

> *P6: 'That if you want to pass, if you want to get everything done by the deadlines, which you need to do on the course, you ultimately have to work all hours under the sun a lot of the time…*'

For many participants, these beliefs that others expected them to work additional hours and that this was required to complete their professional responsibilities were generalised into their post-qualification beliefs about their well-being.

> *P:6 'I almost carried that over into qualified life. So then I would be so used to just working all the time. But if you got to five o'clock and I still had the stuff to do up, you know yeah, sure like, and then I would just be carrying on,'*

This seemed to demonstrate how learned working practices during training 'just rolled over' (P4) into post-qualification, almost becoming the

participant's default way of working. One participant, however, acknowledged the expectation to work additional hours but identified this as unhelpful and spoke of their ability to boundary their behaviour around working hours once qualified.

> *P:10 '…I think these bad patterns get ingrained during training… I think it's completely damaging to well-being. I see it play out in my friends and even on placement, and since qualifying friends will work on the weekend to catch up on work or their logging onto their emails, and I'm like absolutely not; no way you don't pay me to do that I'm not doing it.'*

The experience of a lack of boundaried working hours and practices during training appeared to facilitate a move towards an increased rigidity in terms of setting boundaries and how they applied their job description in their post-qualification practice. For this participant, there was almost an oppositional response to their training experience.

Theme 3: Connection Maintains Well-being

A central theme in participants' learning experiences was the connection with others and the meaning that they placed on this connection.

Validation through shared experience with the cohort

The majority of participants expressed that their fellow trainees were an essential source of support that 'kept them going' (P7) through training. There was a general sense that participants would have felt unable to manage the training process without having a 'cohort of support' (P2). Having a group of peers experiencing the same or similar challenges was validating for participants and formed an essential aspect of supportive cohort relationships.

P8: '…I think some of the kind of the nice things that that I kind of learned was actually about that sense of kind of peer camaraderie, sort of validation. I don't think - there are lots of things that are problematic, I guess, about my training experience, but the one thing that wasn't was the people I was training with and having that was such a massive support system to me at the time.

For some participants, there was meaningful learning around the importance of shared experience and how this is related to an increased understanding from others which participants valued.

P: 7: '…I certainly learned the value of peers, and I think that's still something that I draw on now post-qualification. I had a really good group of friends within my trainee cohort, and we're still good friends now, and I think that really showed me the value of being able to have peers who are in a similar situation if not the same situation as you and they have that sense of understanding that maybe your family or friends don't have.'

Participants experience of support from their cohort led to them feeling understood and validated their experience of distress during training, leaving them to make sense of these relationships as a helpful tool in managing well-being.

Feeling supported by supervisors

Support from local clinical and internal course supervisors was also considered important learning in relation to maintaining well-being during

training. Some participants found that feeling well-supported enabled them to feel more able or motivated to prioritise their well-being.

P10: '…I think the driving force that powered me to [prioritise my well-being] was that I had a really good personal tutor supervisor; he was very supportive..'

For others, supervisors were important in keeping them 'focused on getting through it and getting out the other side' (P11)

P2: '…Luckily had a really, really good supervisor who just kept me on the straight and narrow with it. That was really, really important for my well-being.'

Others made sense of their learning experience by understanding supportive relationships as being helpful in 'navigating' difficulties with well-being.

P:4 '…My local supervisors were always very very good, one of my supervisors was also my line manager through a lot of training as she was always very supportive, and I could go to her with things. And she helped me navigate some of those difficulties.'

When discussing supervision, some emphasis was placed on the importance of relationships with local supervisors; participants' descriptions of their experiences suggested that there was something meaningful about supportive relationships with people who were slightly removed from the training course itself.

Theme 4: Feeling Inadequately Prepared for Post-qualification Life

Regarding the impact of their learning experiences post-qualification, over three-quarters of the participants reported that their experiences had left them feeling unprepared to manage their well-being once they qualified.

Missed opportunities for learning about positive well-being management

Seven of the participants felt that clinical training did not prepare them for the challenges to well-being they would face as qualified CPs. Participants expressed a sense of missing out on opportunities for well-being-related learning, which would have helped them better manage the post-qualification period. Participants highlighted that they experienced training as focused on passing the course rather than on 'equipping us for what being a psychologist is actually like (P8)'.

> *P: 7: '…my experiences of being on the course were that it was very focused on meeting the competencies that you needed to meet and completing the assignments that you needed to complete; I don't think we were taught a lot about how to manage your own well-being and how we can utilise self-care and how important advice all that is post qualification.'*

Two participants talked explicitly about the specific role of CPs in the NHS workforce. They felt that training lacked opportunities to learn what is expected of them within this role and how to be assertive when working in complex NHS systems. One participant reflected on their experience of burnout following training. One way they make sense of their experience is due to missed opportunities to fully learn about the expectations of CPs in the NHS

workforce and how to advocate for themselves professionally.

P4: *'…I think another thing that contributed to the burnout, which the course could have prepared me for, but they didn't, was just knowing what the role should look like. I have the impression that if I was going to my managers and saying this is too much, I can't do this then that's me saying I can't do my job because they wouldn't give me these things to do unless they thought that was part of my job as a psychologist… The NHS is awkward and clunky, and it doesn't always work, and I think you need to be able to point that out and stand up for yourself within that, and that's really important for your well-being, and I don't think the course really prepared, us for that at all.'*

For many participants, including P4, there was a sense of feeling let down and increased vulnerability in the newly qualified stage due to the missed training opportunities and having to rely on others to outline what is and is not expected of them in the workplace.

Counterproductive Learning Experiences

When detailing their ideographic learning experiences relating to well-being during clinical training, several participants described holding onto learned behaviours in their working practice that were unhelpful post-qualification.

P6: '…Yeah, I'm having to unpick a lot of things I learned about working over, prioritising my own well-being, not wanting to disclose etc.'

Participants talked about different ways in which their learning had been counterproductive, as described by P6 above; some were able to identify specific pieces of learning which underpinned these working practices.

P8: '…It's like training sets you up to ignore your own red flags that things are too much because there's just so much to do, and rather than preparing you for post-qualified life, it becomes actively unhelpful.'

Here, P8 describes how they learned to ignore or dismiss signs that their well-being was deteriorating because of a sense that their work demands took priority. For many, a sense of frustration was caused by a felt experience that they had to unlearn these working behaviours and beliefs instilled during clinical training. Participants described this unlearning process as needing to take place to better manage their well-being post-qualification.

For others, their learned response was not just about unpicking aspects of their learning but more of an oppositional behavioural response to their experience.

P: 10 '…I think, if anything, my experiences of well-being during training has given me something- or have left me wanting to do the opposite of what happened in training. So now, if there's any suggestion about really doing some work outside of hours, I'm like, no, absolutely not.'

Discussion

Maintaining well-being is important in preventing burnout and occupational distress in CPs (Rupert & Dorocaik., 2019); however, historically, CPs have struggled to acknowledge this importance (Wise et al., 2012). This study explored CPs' experiences of learning about well-being through training and the impact of this learning post-qualification. To the researcher's knowledge, this study is the first to present findings related to this aspect of CPs well-being experiences.

Using IPA, four group experiential themes were identified: implicit messages about well-being, well-being is not a priority, connection maintains well-being and feeling inadequately prepared for post-qualification life. The first theme refers to *how* CPs learned. The following two focused on *what* CPs learned. Whilst the remaining theme captures the experienced *impact* of CPs' learning. A difference in the experience of well-being stressors during and after training were also observed. Themes are discussed alongside relevant theory and research.

How CPs Learn About Well-being

Implicit Messages about Well-being

Participants in this study described highly influential learning experiences relating to well-being through the receipt of implicit messages from the course staff. Often, these messages demonstrated beliefs held and communicated by 'the course' (a term used by all participants to refer to course staff as a collective) about how CPs were expected to view their well-being and behave in relation to their well-being management. Participants described these messages as unhelpful, negatively impacting their lived experience of well-being and what they learned about managing well-being. Underlying beliefs and assumptions are indicators of OC which can often be unspoken and even unconsciously held beliefs that individuals are unaware that they are holding and communicating to others (McSherry & Pearce., 2018). The participants' experiences in this study may represent deep and underlying manifestations of the OC relating to well-being across DClinPsy training courses (Mannion & Davies., 2018). Little is known about how CPs learn about well-being during training; however, research acknowledges that clinical training programmes are

ineffective at equipping CPs to manage their well-being (Lambert & Simon, 2008). The findings suggest that a significant aspect of CPs' learning about well-being occurs through communicating underlying cultural beliefs and assumptions.

Participants' descriptions of their learning experiences support claims that NHS working practices are heavily influenced by unspoken aspects of organisational culture (OC) (Dixon-Woods et al., 2013); however, the reference to course staff indicates that implicit messages are also part of the academic culture which provides an early insight into the academic culture experiences by trainee CPs. Consequently, the dual identity held by CPs as students and practitioners may make them vulnerable to multiple OCs in their experience of learning about well-being. This aspect of trainee CPs experience is yet to be explored, but the literature would benefit from a deeper understanding of the impact of holding dual status during clinical training. In the meantime, these findings suggest that course providers should carefully consider the different organisational influences when developing and delivering course competencies relating to well-being.

For CPs in this study, learning about well-being was a complex embodied experience, and relying solely on psychological discourse (such as lectures) to address well-being during training may be insufficient to meet the needs of CPs (Stolz., 2014). Embodied learning theories acknowledge the role of the body and emotions in the learning process (Kontra et al., 2012) and are regularly incorporated into primary, secondary and higher education (Rodríguez-Jiménez & García-Merino., 2017; Schmidt et al., 2019). CPs often spoke of their emotional responses to their well-being learning experiences,

thus, highlighting the importance of emotionally embodied learning opportunities for trainee CPs. Embodied learning principles may be beneficial in supporting and improving the well-being-related learning experiences of CPs during clinical training.

Clinical psychology training is among the UK's most sought-after postgraduate psychology programmes (Callahan et al., 2018). There are large numbers of applicants for comparatively few funded places (Scior et al., 2014; Demetri et al., 2023). As a result, there is a culture of intense competition among prospective applicants (Smith., 2014). Through interactions with course staff, participants experienced an expectation from others to be grateful for their training place, which was dismissing of participants' lived experience of training. The experiences discouraged participants from expressing distress relating to course challenges. The application process has been shown to take an emotional toll on aspiring CPs (Demetri et al., 2023); however, the research has not explored the longer-term impact of the application process on CPs. The findings of this study suggest that experiencing the highly competitive application process may contribute to a culture of expected gratitude, which may dismiss the well-being experiences and needs of trainee CPs.

What CPs Learn About Well-being

Well-being is Not a Priority

The importance of culture was apparent in *how* CPs learned about well-being and *what* they learned. Like their medical colleagues (Rich et al., 2016), CPs described learning that there was an expectation to subjugate their well-being needs for their clinical training requirements. Traditionally, the JDRM has

relied on separate models and theories to understand the aspects of OC in the experience of well-being (Lopez-Martin & Topa., 2019), such as subjugation, as they are neither a demand nor a resource (Taris & Schaufeli., 2018). Often the focus in supporting CPs to manage their well-being is to develop personal resources (Pakenham & Stafford-Brown., 2012; Stafford-Brown & Pakenham., 2012). This is evidenced in the BPS core competencies for psychologists, which focus on developing strategies to "'handle' the emotional impact of their work and the ability to monitor their fitness to practice (BPS., 2019, P.19). The researchers argue that the demands and resources experienced by CPs are rooted in the OC of their workplace (Dextras-Gauthier et al., 2012). By focusing only on demands and resources, course providers risk over-attributing well-being management to the individual and not acknowledging the wider environmental impact (Slemp et al., 2015). Expanding the JDMR to include OC theories, as recommended by Lopez-Martin & Topa (2019) could help to contextualise the experiences of CPs and provide a greater understanding of the impact of NHS working cultures. It also identifies OG as an area to target when developing prevention and intervention strategies for supporting CPs well-being.

CPs in this study experienced expectations to work additional unpaid hours, which is commonplace for NHS workers (Kim et al., 2018; Lawn et al., 2020). CPs learned that the requirements of the training were more important than their own well-being, which led to CPs subjugating their own needs. Much like the wider NHS OC, this research provides evidence for an ongoing culture of subjugation which is embedded during CPs clinical training.

Working additional hours can be a significant risk factor in developing

burnout (Lim et al., 2020). However, an interesting distinction exists between the employer expectations of trainees and qualified CPs. It is generally accepted that healthcare staff should not work outside their contracted hours (Warner & Zaranko., 2020); however, this is not necessarily the case for trainees. Trainee CPs are paid NHS employees who also complete a funded academic qualification, which they can use to increase their professional earnings, status, and responsibilities for the remainder of their careers (Clearing House., 2023). Achieving a doctoral-level qualification is a demanding and time-intensive process (Utami., 2019). Doctoral students across various disciplines would be expected to work long hours to complete their studies. Many students work full or part-time alongside their education to fund their studies (Rowe., 2021). Therefore, the expectations on trainee CPs are not unlike those placed on other doctoral or PhD students. Given the personal benefits and the dual role of doctoral students, the expectation of completing some of the academic components outside of work hours may be a reasonable and realistic expectation for trainee CPs. From reviewing the application information, however (Clearing House., 2013) the academic expectations around working hours may not be emphasised clearly enough to prospective applicants. Our findings highlighted that greater clarity and transparency from clinical training courses around the dual role, and expectation of trainee CPs, could be beneficial in managing the expectations of trainee CPs. Well-being may be supported by setting clear expectations from the point of application through to training itself.

Connection Maintains Well-being

Peer relationships have a positive impact on the well-being of healthcare workers. Research has shown positive peer relationships can provide validation (Viswanathan et al., 2020), and enhance coping strategies (Leng et al., 2021). Participants in this study highlighted their supervisors and trainee colleagues as being vital in managing their well-being throughout training. The shared experience within peer relationships was particularly helpful as it provided validation and an increased understanding of the nuances of training that family and friends may not understand. Among healthcare workers, shared experiences have been shown to improve well-being and decrease occupational burnout (Kelsey et al., 2023). As such, this is a really important finding supporting the potential benefit of encouraging peer relationships within clinical training. As such, CPs should be supported and encouraged to form meaningful relationships with their colleagues throughout; this could be achieved through team building, reflective practice, and using compassionate models to underpin team ethos.

The Impact of CPs Learning Post-Qualification

Feeling Unprepared for Post-qualification Life

Ultimately, for 10 participants, their training experiences left them feeling unprepared to manage the challenges they faced post-qualification. Lambert & ' 'Simon's (2008) claimed that clinical training courses fail to prepare CPs to manage their well-being post-qualification, but they do not provide any insight into why this might be. The participants' experiences in this study suggest that CPs may feel unprepared for two reasons: missed opportunities for learning and counterproductive learning experiences.

A substantial body of research details the complexity of NHS systems, including its processes, pathways, and constantly changing economic and legislative landscape (McKee., 2021). Participants described the challenges of working in complex NHS systems and the lack of opportunities to develop essential skills in assertiveness and boundary setting to help them navigate this. The participants' commentary on their experiences of feeling unprepared are concerning, given that the theoretical foundation of the competency-based learning ethos, on which doctorate programmes are built, is to prepare trainees more efficiently for clinical practice (Kenkel & Peterson., 2010). It highlights the importance of adequate consideration and pre-qualification preparation for the transition from trainee to CP and the associated challenges of the NHS context to enable trainees to feel adequately prepared to manage their well-being.

Participants also reported that much of their learning experiences around well-being during training were not helpful to their well-being post-qualification. The difference in experienced job demands for trainee and qualified CPs indicates that learning about well-being as a trainee might not be transferable to managing the different pressures and expectations faced post-qualification. According to Melesis's Transitionary Model as applied to student nurses, upon qualification, there is a transition from the role of student to the qualified practitioner (Melesis., 2010). Throughout this transition, the practitioners, in this case, CPs, must learn to adjust to the new expectations and demands of their qualified role (Wildermuth et al., 2020). It is common for practitioners who transition from higher-level academic qualifications to feel overwhelmed by their new job demands and feel unprepared (Unruh and Nooney., 2011). Additionally, the change in responsibility may leave CPs feeling as though the well-being

strategies they learned during training do not meet their post-transition needs. The level of social support, and guidance available from staff members during the transitionary period, can significantly improve the success of the transition period for student nurses (Meleis., 2010) and could be a helpful target for interventions to support CPs' well-being during the transition to post-qualification.

One counterproductive learning experience described by participants was learning to 'to ignore your own red flags' (P8), and they made sense of this as being because there was 'so much to do'(P8). By being encouraged to place the job demands ahead of their well-being, participants learned to ignore signs that their mental health and well-being were deteriorating. Once again, this highlights that not only is the longstanding NHS culture of subjugation (Mackenzie., 1995; McCarthy et al., 2020) a potential aspect of OC within the DclinPsy training, but the findings provide an insight into how this is learned during training, and the subsequent impact on well-being management. This learned behaviour around ignoring signs of declining well-being may have serious implications for CPs' well-being post-qualification and warrants further investigation.

Ultimately, the findings of this study suggest that OC may negatively impact CPs well-being-related learning experiences during training. Supportive supervisory and peer relationships may play an important role in maintaining CPs well-being pre- and post-qualification; however, the post-qualification transitionary period for CPs can present challenges to well-being. The differing experiences and expectations of trainees and qualified CPs may contribute to the difficulties experienced during the training and transition period.

Implications and Recommendations for Clinical Psychology

Well-being beliefs and assumptions held by the DClinPsy community may be shared, learned and maintained through implicit communication with other community members, including course staff, different training cohorts, and NHS placement providers. Findings suggest that training course providers may benefit from focusing less on providing formal well-being learning opportunities, such as lectures and workshops (Choi and Jacobs, 2011), and more on identifying embodied experiential learning relating to well-being opportunities. By examining (Panescu., 2021) underlying beliefs and assumptions about well-being (Schein., 1998;) held by the different members of the DClinPsy training community and how these are communicated to trainees throughout their training DClinPsy courses may be able to improve CP's positive well-being learning experiences.

Additionally, the interpretation of participants' lived experiences suggests an expectation to subjugate one's well-being needs in place of role or course demands is being communicated to CPs during training. This highlights an identifiable behavioural feature of OC. Courses may benefit from exploring the underlying beliefs relating to subjugation and how this is being communicated through espoused values (Macfarlane et al., 2013), such as written communication to CPs.

By engaging in the suggested explorations of OC, course providers may be able to develop a greater sense of the well-being culture within the DClinPsy and how this contributes to CPs' individual learning experiences as well as the socially cohesive behaviour concerning well-being within clinical training and post-qualified CPs (Macintosh & Doherty., 2008). Each of the 30 training

course providers will likely have distinct well-being cultures shaped by the host university, local geographical and cultural influences and senior management team. As such, each DclinPsy course should aim to individually explore the beliefs and assumptions about well-being and how these manifest in their DclinPsy training programme to help identify opportunities for meaningful change (Mannion & Davies., 2018). Courses could do this by assigning independent clinicians to complete observations and evaluations of all aspects of the course, including the perspectives of course staff, clinical supervisors and trainees, and providing a written report. This could be shared with existing and previous DClinPsy community members for comment and used to generate target areas for development. A brief literature review found no evidence of explorations such as this in any other NHS training courses; as such, there is an opportunity for DclinPsy courses to champion this type of exploration of OC and well-being in professional training courses.

To draw upon the potential benefits of connection with others, training providers and local NHS trusts should consider fostering supportive relationships within teams, services and organisations. There are several ways in which teams may choose to do this; Schwartz Rounds provide structures forums for staff across all levels of an organisation to connect over shared experiences regarding the emotional impact of their work (Flanegan et al., 2020), which peer support groups specifically for trainee CPs and newly qualifies CPs may provide safe spaces free of fear of assessment or appraisal from senior staff (Ooi., 2019). DclinPsy courses may benefit from encouraging the development of a clan-based culture where all members of the DclinPsy

community are encouraged to value and foster kinship, mentoring, teamwork and collaboration (Cameron et al., 2022).

This research suggests room for improvement in the experience of learning about well-being for CPs. To maximise learning opportunities during training, the researchers propose adding a tenth core competency to the BPS framework (BPS., 2019), called ‘Personal and Professional Well-being’. This competency would focus on developing personal resources, awareness of organisational culture theories and research, ability to observe and critically assess organisational cultures, reflection on their well-being learning experiences, fostering a connection with others, and preparing for the transition to post-qualification. Incorporating this into the core competencies framework means that course providers would be audited and regulated on the effectiveness of this aspect of their course provision as part of the re-accreditation process.

Limitations

Interpretive Phenomenological Analysis

The researcher's position as a trainee CP will have shaped the design, data collection, development, and interpretation of the findings (Smith et al., 2022). As detailed above and in the supporting appendices, the researcher took several steps to minimise the risk of bias and ensure that the researcher remained committed to an iterative approach to GET development, being led by the data at all times. The researcher has endeavoured to provide a high level of transparency concerning reflexivity, rigour and credibility, enabling the reader to determine the study's quality and credibility. Though this is a fundamental

aspect of IPA, the researcher acknowledges that their relationship to the phenomenon of interest increases the risk of researcher bias in the analysis and interpretation.

Population and Sample

The population sample was small, and there was a lack of diversity, particularly regarding gender and race. A robust justification exists for a smaller sample within the IPA methodology (Smith et al., 2021). The aim here was to explore the lived experiences of a small homogenous group and generate findings that, when applied tentatively, could be meaningful to a larger, appropriately homogenous group. The lack of diversity, however, is important as it reflects the lack of diversity in the wider clinical psychology field (Callahan et al., 2018). Future research would benefit from greater gender diversity, whilst similar explorations could focus specifically on the experiences of people from UK minority groups, typically underrepresented in clinical psychology (Dimmick & Callahan., 2022).

Due to the volunteer sample, there is likely to be a sampling bias here, as participants likely chose to participate because they had an invested interest in well-being due to their lived experiences (Tiit et al., 2021). This is likely to impact the sample's representativeness.

Contextual Demographic Information

Researchers did not ask participants to disclose which DClinPsy course they completed. As a result, findings could not be discussed in the context of the individual’s training course. Opportunities for considering divergence and convergence of themes, such as experiences of connection for those with larger versus smaller cohorts, were missed. Given how many clinical psychologists go

on to work on or in conjunction with training providers, the decision not to record training institutions felt more aligned with the principles of IPA in enabling participants to share their lived experiences and meaning-making organically.

Expansion of DClinPsy Training

In 2021, Higher Education England to increase UK training places for CPs by 25% (Bawa et al., 2021). As a result, course providers have been tasked with supporting more trainees than ever without significant increases in resources or NHS capacity to provide placements. Unfortunately, as these changes are relatively recent, there is a lack of research or anecdotal accounts that explore the impact of the expansion of courses on the experience of trainees. As this research is the first to explore CP's well-being learning experiences during training, researchers cannot comment on the impact of the expansion of DClinPsy courses on the well-being learning experiences captured in this study.

Further Research

Findings indicate that a more focused exploration of the role of implicit communication in well-being learning across DclinPsy courses may be beneficial. Researchers may wish to consider discourse analysis which can facilitate an exploration of how language is used in conversations relating to well-being and support a larger sample size (Paltridge., 2021). Researchers should consider multiple perspectives in their exploration of DClinPsy culture and well-being. Thus, qualitative explorations from the perspective of Clinical Psychology doctorate staff, who hold a different hierarchical position to trainees (Ovseiko & Buchan., 2012) may also provide insight into the learning culture

relating to well-being.

Participants experienced feeling unprepared for post-qualification. The field may benefit from a large-scale quantitative study exploring clinical psychologists' transition from pre to post-qualification. Researchers may wish to use a transition theory adapted for healthcare training, such as the one posed by Meleis (2010), as a theoretical basis for the enquiry. As this would be the first study of its kind, a broader exploration of the transition process, with some space for more specific enquiry related to preparedness, may benefit. This may provide a greater understanding of CP's transition into post-qualification, inform the clinical psychology training process and provide guidance for supporting the transition, as has been demonstrated by research relating to nurses (Kumaran & Carney., 2014).

Conclusion

This IPA study aimed to explore CPs well-being related to learning experiences during clinical training and the impact of this post-qualification. This study found that much of CPs learning occurs through implicit communication of underlying beliefs and assumptions about well-being between CPs and DClinPsy course staff. Participants' experiences highlighted a well-being culture in which individuals learned that well-being is considered to be less important than job demands and where many CPs feel pressure to work unpaid hours. Participants found validation and support in their relationships with peers and supervisors which appeared to support individual experience of well-being. The well-being learning experiences during training left many participants feeling unprepared for the challenges of post-qualification work and in a position where they felt less equipped or able to notice signs that their well-being needed

attending to.

The analysis demonstrates that an increased focus on understanding and exploring the underlying beliefs within and across DclinPsy course providers may be beneficial in understanding how to make meaningful changes in the well-being and learning experiences of CPs. By including well-being as a core competency DclinPsy courses may be able to provide a structure within which they can better equip CPs for long-term careers in the NHS. Individual course audits exploring different manifestations of well-being culture across the DClinPsy provision may help to generate evidence to support culture change.

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Appendices

Appendix A: University of Exeter Ethical Approval

Dear AMY PETERS

Ethics Application ID: 510805

Title: How does clinical psychology training prepare clinical psychologists to manage their own stress and well-being? Exploring the experiences of newly qualified Clinical Psychologists.

(Version: 1.0)

Proposed Project Duration: 1 Jan 2022 - 30 Sep 2023

Your research study ethics application submitted above on 28 Feb 2022, 11:21 has been reviewed by the FHLS Psychology Ethics Committee.

Outcome decision by Research Ethics committee: Approved

Generally fine. I am happy to approve this application conditional on (i) implementation of the following points and (ii) obtaining the necessary HRA approvals:

Information sheet:
- at an early stage in the document, clearly state the researcher's trainee status and that they are doing the study for their DClin thesis research, so this is upfront for participants.
- confidentiality section has some words missing: please state when participants' personal data will be deleted (presumably after 1 month), state who will be able to access the video/audio and participant personal data; state explicitly when video/audio will be destroyed.

Furthermore (non-essential) please consider giving participants the option of reviewing their transcript and making amendments/deletions to it, and make any consequential amendments to the PIS/debrief.

Decision Date: 8 Mar 2022, 12:12*

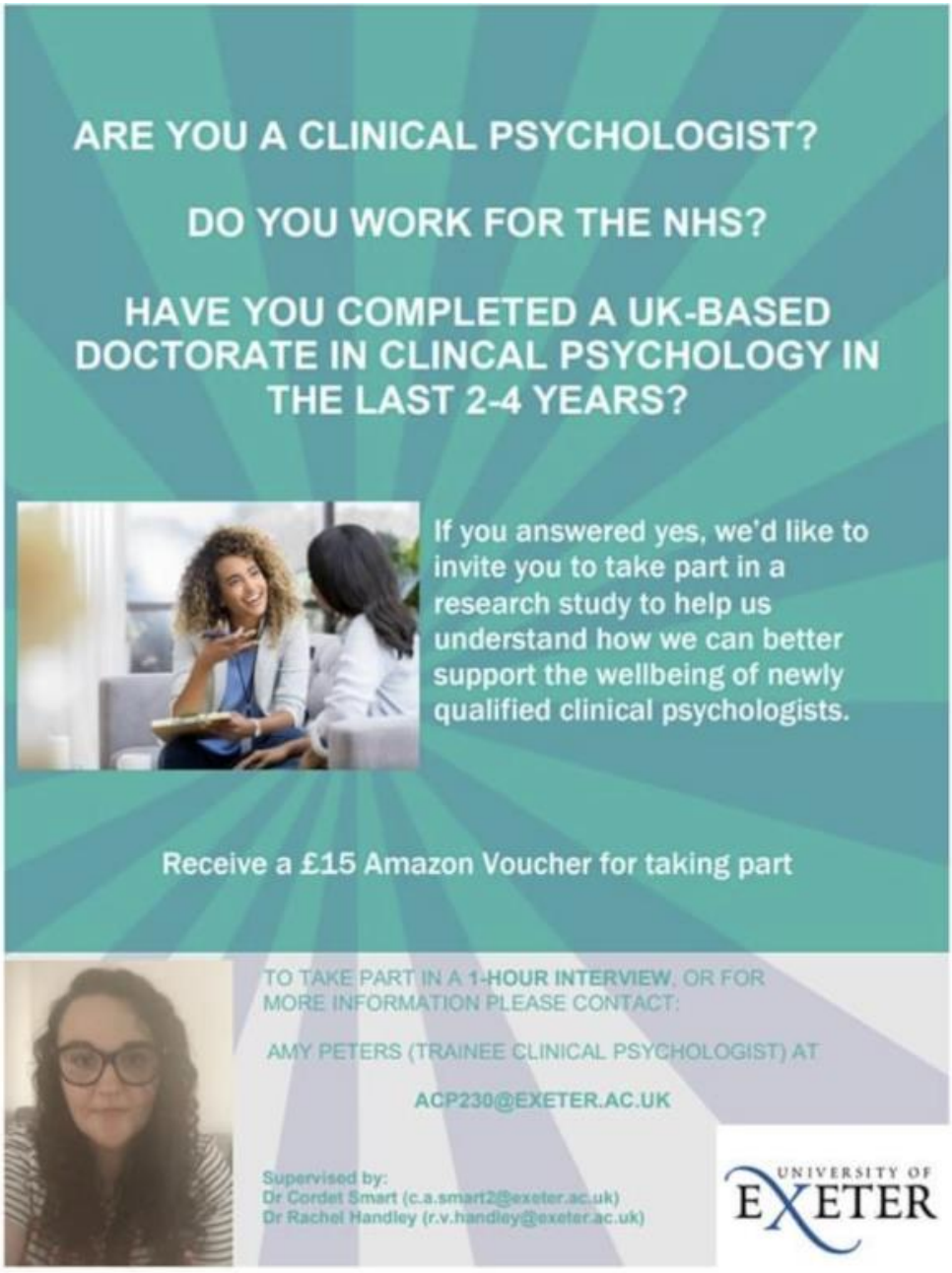
You can only start your research once you have received an **Approved outcome. The start date of your research will be no sooner than the Ethics Committee Approval decision date above.*

Research Ethics Committee Approval End Date: 8 Mar 2023, 12:10

Regards,

FHLS Psychology Ethics Committee

Appendix B: Research Poster



Appendix C: Targeted Social Media Pages

Social Media	Group or Content Name	Membership / Following	Description
Facebook	Trainee Clinical Psychologist Group UK	1.4K	UK-wide group for current and recently qualified trainee clinical psychologists
Facebook	Psychology Research	7.3K	Platform for recruitment to UK-based research relating to psychology
Instagram	The Oxford Psych @theoxfordpsych	16.2K	Clinical Psychologist and digital content creator – provides a platform for research conducted by Trainee Clinical Psychologists

Appendix D: Participant Information Sheet

Title of Project: How does clinical psychology training prepare clinical psychologists to manage their own well-being post-qualification. Exploring the experiences of newly qualified clinical psychologists.

Researcher name and background: Amy Peters**:** Trainee Clinical Psychologist at the University of Exeter. This research is being completed as part of the researchers Doctorate in Clinical Psychology Studies.

Invitation and brief summary:

We would like to invite you to take part in the above research which seeks to explore what Clinical Psychologists recall learning about managing their well-being during training and how they apply this learning post-qualification. We know that clinical psychology training can be a very challenging time for trainees in regards well-being, but we also know that there are several challenges faced by qualified clinical psychologists which may impact on their well-being and increase the risk of burnout.

Due to the impact of years of austerity measures, on top of an increased demand for mental health services, and the ongoing impact of COVID-19 the NHS has become an increasing challenging place to practice as a clinical psychologist. Clinical Psychologists face an increased risk of poor well-being, developing burnout or compassion fatigue due to the challenges inherent in their work (Lloyd, 2017). We know that around 94% of trainees go on to work in the NHS, however many are Increasing numbers of clinical psychologists are later choosing to practice outside of the NHS, citing high demand, pay, stress and burnout as contributing factors (Summers et al., 2021). The NHS is currently facing significant challenges in the recruitment and retention of staff across several disciplines however, maintain good well-being can help to mediate the risk of burnout in clinical professions. For this reason, the researchers are interested in exploring what clinical psychologists feel they learnt about managing their well-being during training and how they apply this learning post-qualification.

Please take time to consider the information carefully and to discuss it with family or friends if you wish, or to ask the researcher questions.

Purpose of the research:

Ultimately, the intention is to be able to provide best practice recommendations for Doctorate in Clinical Psychology course providers on preparing Clinical Psychology Trainees to work in an ever evolving, demanding and challenging context of the NHS. The researchers also hope that by doing so, we might be make best practice recommendations for NHS trusts,

employing Clinical Psychologists about support retention of clinical psychologists. Finally, the researches also hope that this project will enable us to develop recommendations which help to support Clinical Psychologists who take on roles such as ‘well-being lead’ to share their learning with their teams, supervisee’s and allied healthcare professionals as part of the Clinical Psychologists Role.

Why have I been approached?

You have been asked to take part in this research project because you are a qualified Clinical Psychologist and completed a UK based Doctorate in Clinical Psychology Programme (DClinPsy) in the last two to four years. You have registered your interest in this project by responding to a public social media post, a post in a private social media group specifically for Trainee and or Qualified Clinical Psychologists, or have responded to a recruitment email sent by your training course provider.

We are hoping to recruit between 12- 15 clinical psychologists from DClinPsy programmes across the UK. We would really value hearing the experiences of Clinical Psychologists from a range of social, racial, economic, religious, and neurodivergent backgrounds and hope to be able to reflect a diverse range of experiences in the field of clinical psychology.

What would taking part involve?

Participants would be asked to take part in a one hour online interview using Zoom Video Conferencing Software. The interview would explore your experiences of managing your well-being during training, how your understanding of your own well-being evolved during that time, and how you have used that learning in your first few years as a qualified clinical psychologist. It is important that you are able to complete the interview in a confidential space, where you feel able to talk freely about your experiences. At the end of the interview, there will be a short debrief with the lead researcher and you will then receive a debrief document, which will summaries the project for you, and will also include information about withdrawing from the study and accessing any support you might need afterwards.

Once your interview has been completed, the research team will remove any personally identifiable information that’s deemed not to be relevant to the study, this will include your name, and if mentioned, the area or NHS trust that you work in, team or colleague names, your training course provider etc. You will be given a pseudonym, and all video, audio and transcribed documents will be saved under your pseudonym. Only the researcher will have access to a document that links your personally identifiable data, to you pseudonym.

What are the possible benefits of taking part?

Research can offer valuable contributions to society in lots of different ways, and the research team hope that this study will help support the psychology profession however, everyone’s experience of taking part in research is very different and so we can not promise

that you will experience any particular benefits by taking part however you might experience some indirect benefits of taking part in the research project.

What are the possible disadvantages and risks of taking part?

Many of the questions in this study involve asking you to reflect on your experiences during training, and your journey with well-being. We apperceive that this is a topic area that might be difficult to talk about and could be upsetting for participants. Participants can stop the interview at any time, if they no longer wish to continue, they can choose not to answer an questions that feel upsetting. The research team will provide participants with a face to face debrief at the end of the interview, and the debrief document will also include a number of organisations, specifically for healthcare workers, which can offer support if you'd like to access these after the interview.

As the interviews are taking part online, there may be a change that the connection fails during the interview. When you book in for your interview you will be asked to provide a contact number, the researcher will contact you by phone if the connection fails. Your telephone number will be deleted once the interview has ended.

What will happen if I don't want to carry on with the study?

Participation in the study is completely voluntary. If at any point before, or during the interview you decide you would like to withdraw from the study, you can do so by telling the lead researcher. The interview will end at this point, and a debrief will be offered. You do not need to give the researcher a reason why you wish to withdraw. If you would like to withdraw from the study, after the interview has ended, you can do so for up one month after the date of your interview. To withdraw, you can email the lead researcher on acp230@exeter.ac.uk. Your data will be deleted immediately. After this time, the data analysis will have started, and it will not be possible to withdraw your data.

How will my information be kept confidential?

The University of Exeter processes personal data for the purposes of carrying out research in the public interest. The University will endeavour to be transparent about its processing of your personal data and this information sheet should provide a clear explanation of this. If you do have any queries about the University's processing of your personal data that cannot be resolved by the research team, further information may be obtained from the University's Data Protection Officer by emailing informationgovernance@exeter.ac.uk. or at http://www.exeter.ac.uk/ig/.

Your data will be collected through zoom, in three different formats. An audio video recording, and audio only recording, and a transcription document. The data will be imported from Zoom and stored on the Lead researchers University of Exeter OneDrive account. A link document, which links your personal data (for example your name) with your pseudonym will also be stored on the Lead Researchers University of Exeter OneDrive account separate to your data.

Your personally identifiable data will only be accessed by the research team and will be destroyed one month after your interview takes place. This is a secure password protected education platform. This will be accessible by a password protected computer. Your will only be accessed by the three members of the research team. Once imported, the transcript document will be checked against the original audio video recording, from that point on, the transcription document will be the main way your data is viewed by the research team. Your data will be deleted after 5 years.

Will I receive any payment for taking part?

Participants will receive a £15 amazon voucher for taking part in the study. Participants who email the researcher for further information, or who book an interview slot but do not attend, will sadly not be eligible for the £15 Voucher. Participants who commence the interview, but end it early, or choose not to answer some questions or withdraw during the study will receive the amazon voucher. Participants who complete the full interview will also be eligible for the voucher. The voucher will be delivered by email, not later than one month after the interview has taken place.

What will happen to the results of this study?

The results from the questionnaire will contribute to my Doctorate in Clinical Psychology Major Research Project, which will be submitted to the University of Exeter. The research team also hope to submit the research for publication. Participants can request a copy of the completed research paper from September 2023.

Who has reviewed this study?

This project has been reviewed and approved by the Research Ethics Committee at the University of Exeter (510805).

Further information and contact details

For further information please contact Amy Peters acp230@exeter.ac.uk (Lead Researcher). If you are not happy with any aspect of the project and wish to complain please contact Dr Cordet Smart (Lead Supervisor) at c.a.smart2@exeter.ac.ukor Gail Seymour, Research Ethics and Governance Manager on g.m.seymour@exeter.ac.uk, 01392 726621.

Thank you for your interest in this project

Amy Peters
Trainee Clinical Psychologist

University of Exeter

Appendix E: Consent Form

Title of Project: How does clinical psychology training prepare clinical psychologists to manage their own well-being post-qualification. Exploring the experiences of newly qualified clinical psychologists.

Name of Researcher: Amy Peters (Trainee Clinical Psychologist)

Please initial in the box

1. I confirm that I have read the participant information sheet dated 2802/2022 (Version No.1) for the above project. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time during the interview, and for up to one month after the interview date without giving any reason and without my legal rights being affected. ☐

3. I understand that relevant sections of the data collected during the study may be looked at by members of the research team, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

4. I understand that taking part involves providing identifiable personal information which will be anonymised to the best of the researcher's ability using pseudonyms. ☐

5. I understand that the questionnaire interview transcripts, will be stored securing during the project, and for up to five years after my interview takes place. After this time, it will be destroyed. ☐

_____ _____ _____

Name of Participant	Date	Signature
_____	_____	_____
Name of researcher taking consent	Date	Signature

When completed: 1 copy for participant; 1 copy for researcher/project file

University of Exeter

Appendix F: Demographic Questionnaire

1. What is your age?

- ☐ 18-25
- ☐ 26-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65 and over

2. How would you describe your gender?

- ☐ Man (including transgender man)
- ☐ Women (including transgender woman)
- ☐ Non-Binart / Gender Non-conforming
- ☐ My identified gender is not listed above _____
- ☐ Prefer not to say

3. How would you describe your ethnicity?

- ☐ Asian or Asian British- Indian
- ☐ Asian or Asian British- Bangladeshi
- ☐ Asian or Asian British- Pakestani
- ☐ Asian or Asian British- Chinese
- ☐ Asian or Asian British- Korean
- ☐
- ☐

Asian or Asian British- Japanese

Asian or Asian British- Other _____

☐ Black, Black British, Caribbean or African – Caribbean

☐ Black, Black British, Caribbean or African – African

☐ Black, Black British, Caribbean or African – Other _____

☐ Mixed or multiple ethnicity _____

☐ White - English/ Welsh/ Scottish/ Northern Irish/ British

☐ White –Irish

☐ White - Gypsy / Irish Traveller

☐ White- Roma

☐ White- Other _____

4. How would you describe your sexual orientation?

☐ Homosexual

☐ Heterosexual

☐ Bisexual

☐ My sexual orientation is not listed here _____

☐ Prefer not to say

Appendix G: Interview Schedule

Approximately 1-hour Semi-Structured Interview. Questions were designed to be used as a guide for the interviews and not as a prescriptive list of questions.

Before the interview begins

Introductions

- Brief introduction chat
- Thank you for participating
- Reminder of the purpose of the interview

House Keeping

- Plan if the Zoom connection drops
- Check out private space, which feels safe enough for the interview

Right to withdraw

- Reminder of the participant information sheet
- Right to withdraw at any point during or up to one month after

Ethics and Governance

- Anonymisation of identifiable data

Questions and Consent

- 'Do you have any questions about anything I have mentioned/ anything in the pre-interview information?'
- 'Do you still consent to take part in the study?'

Procedure

- With permission, start the recording
- The interview will last around 1 hour
- The recording will be stopped
- Space for questions, and debrief and arrange to deliver your Amazon voucher.
- 'Are you happy for me to start recording?'

START RECORDING

Brief Introduction Question

What does the term well-being mean to you?

Wellbeing and Clinical Psychology Training

2. **Can you tell me about your well-being through your training journey?**
   (Prompts: You might like to think about your well-being before training started, right through to when you graduated).
3. **What did you learn about managing your well-being during training?**
   (Prompts: What you learned could have been from the process/content of training, or it could have been from outside of the course; could you give examples of how you learnt those things?)
4. **Can you tell me how your understanding of / approach to managing your well-being changed or evolved during training?**

Post Qualification experiences of managing well-being.

5. **Can you tell me about your well-being journey as a clinical psychologist since you qualified from training?**
   (Prompts: What have been some challenges to your well-being as a qualified Clinical Psychologist? Any similarities or differences in your experiences of well-being pre/post qualification?)
6. **How have the things you learned about your well-being during training impacted how you manage your well-being in your current work?**
   (Prompts: What you learned could have been from the training process, or it could have been from outside of the course, specific skills, techniques etc. Impacts could be positive or challenging. Thoughts, feelings, behaviours at work/ home)

Overview

7. **Is there anything else you feel Is important or meaningful about your experience of learning about well-being that I haven't asked you about?**

STOP RECORDING

Debrief

- Thank the participant for taking part
- Acknowledge content may be difficult, and remind participants of signposting support on the debrief document.
- Send the debrief document and amazon Voucher via email immediately after the interview.

University of Exeter

Appendix H: Debrief Information Sheet

Title of Project

How does clinical psychology training prepare clinical psychologists to manage their well-being post-qualification. Exploring the experiences of newly qualified clinical psychologists.

Summary of Participation

Thank you for taking the time to complete this research. We appreciate you taking the time to share your experience with us and helping us to achieve the aims of our research.

You have taken part in a study that seeks to explore what Clinical Psychologists recall learning about managing their well-being during training and how they apply this learning post-qualification. We know that clinical psychology training can be a very challenging time for trainees in regards to well-being (Cushway and Tyler, 1994., SchwartzMette, 2009; Skovholt, Ronnestad, & Jennings, 1997), but we also know that there are several challenges faced by qualified clinical psychologists which may impact on their wellbeing and increase the risk of burnout (Barns, 2017). Burnout is a common reason why psychology staff leave the NHS to seek other opportunities. The NHS is currently facing significant challenges in the recruitment and retention of staff across several disciplines; however, maintaining good well-being can help to mediate the risk of burnout in clinical professions (Rehman, 2020). For this reason, the researchers are interested in exploring what clinical psychologists feel they learnt about managing their well-being during training and how they apply this learning post-qualification.

By participating in this research, we hope that you will help the researchers provide best practice recommendations for Doctorate in Clinical Psychology course providers for preparing Clinical Psychologists to work in an ever-evolving, demanding and challenging context of the NHS.

Withdrawing from the Study

If you wish to withdraw from the study, please remember that you can withdraw your data up to one month after the date you completed your interview. You can do this by contacting Amy Peters at acp230@exeter.ac.uk. You do not need to provide a reason, and you will still receive your £15 amazon voucher.

Additional Support

We hope you have not experienced any distress or discomfort from taking part in this study. If you have found your experience distressing or would like to access support for your

wellbeing, you will find information on support services for healthcare professionals across the UK listed below. You can access these services now or at any point in the future.

Project5

Project5 is a not-for-profit organisation that provides a unique service to NHS staff and healthcare workers by delivering access to structured and highly skilled support designed to enable success at work. The support focuses on activating people's strengths to achieve balance and connectedness to their purpose at work. They have over 1,000 highly skilled and trained Coaches, Psychologists, Therapists to work with staff whilst they are capable of effecting change in their own lives. To provide contact, through FREE 1-to-1 sessions, to those who notice that they are becoming impacted by their work. They also offer free self-help information on their website.

Project5 are partnered with NHSE to support the NHS in taking care of their staff, but they remain an independent organisation. This means that contact with Project5 is confidential and can not be traced by employers.

Project5 is a UK wide offer to all NHS staff and supporting healthcare workers.

https://www.project5.org/

Healthcare Workers Foundation

Healthcare Workers' Foundation (formerly known as HEROES) is a charity founded by NHS workers for NHS workers. They offer healthcare workers of all disciplines support with welfare and wellbeing during the COVID-19 crisis and beyond.

Their services cover all healthcare workers' physical, mental, and day-to-day needs, from doctors and nurses to cleaners and porters.

https://healthcareworkersfoundation.org

GP

If taking part in this research study has left you feeling as though you might like to access more formal support for your mental health and wellbeing, please get in touch with your GP or your local walk-in centre, who will be able to discuss your current experiences with you, and discuss options for support.

Emergency Support

If you have harmed yourself or have taken an overdose, you can call the emergency services on 999 or attend your local A&E department.

If you would like any additional information about the research, you can contact the researchers using the information provided below.

Amy Peters (Trainee Clinical Psychologist) on acp230@exeter.ac.uk
Dr Cordet Smart (Lead Supervisor) on c.a.smart2@exeter.ac.uk

Ethical approval was provided by Exeter University. If you would like more information about this, you can contact the Ethics Committee Chair using the information below:

Dr Nick Moberly Ethics Committee Chair Health and Life Sciences- n.j.moberly@exeter.ac.uk

Once again, we thank you for your time and sharing your experiences with us.

Amy Peters (Trainee Clinical Psychologist)

Appendix I: Example of Coding and Experiential Statements from P1

	P: yeah. So I interestingly, when I was an	Told the NHS will not priorities her wellbeing.
As an assistant, told the NHS will not look after you	assistant, this is pre training, somebody told me the NHS will not look after you, you have to look after yourself but obviously I	Pre training – overworked to prove capability to others.
Must look after self	was an assistant and I would have done	
Wanted to be seen as capable	anything kind of it'd be seen as a competent and capable and taken on too much and even	
Took on too much	for roles. I think that that is that that is something that I have noticed, you know that	Experiences wellbeing as being insincere and tokenistic.
Wellbeing involves a lot of Lip service tokenistic?	actually there's lots of lip service to it, I think. So I do feel that some of the well-being things were very tokenistic, and I also feel that the same way in that, I think that there's two things there's one about well-being very tokenistic, and then there's	
Questioning motivation behind wellbeing	another thing about what the wellbeing for. So I feel like the well-being often gets	Questioning the motivation for wellbeing promotion.
Look after self to be able to look after others	driven into that 'if you don't look after your well-being you're not looking after other people'. And I feel that us as helpers,	Identifies as a helper, not just as a psychologists
Helper	or you know, obviously can't speak for anybody else, I can only speak for myself,	
Does she feel she needs to justify this?	but as a helper obviously there's lots things around that isn't there reading and research around what it is to be a helper, in that you	
Frustration?		

Own needs take a back seat. Others more important?	want to do well for other people. I think you do put your needs on a backseat and then you end up on a course where obviously you're ending up getting trained into basically being you know incredibly skilled helpers. Incredibly, skilled at helping to manage other people's well-being and that really being your focus and I think that that that's there's one thing I think that there was a lot of talk about well-being, but often it was in terms of practice. So it was kind of on my course anyway, there was the kind of well-being, but it was terms of like reflective practice and it was almost to make you a better psychologist rather than necessarily just solely to look after yourself, and then there was often this message that thinking about your wellbeing makes you better helpers quite often rather than actually what I, I think it would have been nice to have done is that actually you just sometimes just really need to look after yourself. And they're being space for that. So it not necessarily being a thing that's assessed, because actually we had you know interesting reflective practice group we still had members of the team within them, so you do feel constantly assessed, even if it's necessarily meant to be something that's meant to be free from that as well. And, and in terms of the tokenistic, I feel that that	Expressing frustration at motivation for wellbeing for helpers being to support others.
Course trains you to be a skilled helper		
Trained to manage others wellbeing.		
Others are the focus. Others are the propriety?		For those promoting wellbeing, the needs of the client are more important than the needs to the helper.
Wellbeing discussed in regard to practice		
Aim of Well-being and reflective practice was to make you a better psychologist		Wellbeing is related to improving and ensuring good practice not for self care
Not to look after self		
Received message - wellbeing makes you a better helper Frustration? / Disappointment?		Powerful and frustrating messages around wellbeing making you a better helper.
Feels message should have been to just look after yourself for yourself.		
Wellbeing shouldn't be linked to assessed work		Well-being should be for the self, not others.
Felt assessed during reflective practice Not able to be truthful? Worried about judgement?		Fear of judgement inhibited openness.

that is often what happened during the course

Support was often reactive

that there'd be, so say I was.

Course wellbeing support was reactive, not proactive.

Significant event in the local area

You know, or it would be in response to

crisis, a very reactive often so obviously

Big response to the event

where I trained with those very significant

and traumatic incident that that happened and

Course team offered support in response to the incident

in the local area and. And there was

obviously quite a huge response to that, in

Critical of support- too slow

terms of the team, so they came in and kind

of said, you know if there's anything that is

Response should have been more proactive

Frustrated?

Disappointed?

really struggling you know the course team

are always open to that. And, but obviously I

think that there should be a more proactive

Gratitude for support received.

Grateful for reactive support

bit as well, so I am grateful, of obviously

Saying what should be said?

that there was that reactive thing and I fed

back during that that they, you know that

Gave positive feedback

that was a real value.yeah and then also

there wasn't necessarily the kind of

Lack of preventative approach made wellbeing support feel tokenistic

preventative proactive approach to well-being

Parallels between course wellbeing approach and NHS feeling tokenistic.

and sometimes it that I think that's why

sometimes it feels a bit tokenistic. And I

Similar in the NHS

think this the same with the NHS in

particular, I think that often there is well-

Wellbeing is to help keep NHS going

being, for you know, to help the system keep

Feels motivation is to reduce sickness and improve productivity.

going as well because, obviously, if they

Focus on less sickness

focus on well-being, It is to make sure that

Working to best of ability

there's less stuff sickness is to make sure

that there's less and that you know that we

Sense of not being valued as an individual

have keep working to the best of our ability

and we're excellent helpers not necessarily

Wellbeing not necessarily for own benefit.

Function of wellbeing – to ensure efficient and skilled helpers	I feel like, the function of it is to make sure that we're efficient and skilled helpers that are in post and that don't kind of cost the NHS more than it has. And we kind of get told how much the NHS is paying for our things as well, so you do feel like you owe a lot, and obviously I'm very grateful, and I do feel a sense of that guilt, but I think in terms of who you're speaking to like often I don't think there's many people that are in our profession and I'm certainly not one of them, that would like to you know defraud the NHS or feel like we're not, I think we often give and I certainly do I give up above and beyond, You know my time and my resources to help others, and so I think it's about the audience as well, often it's done to that all making you feel guilty sometimes to take time out.To take the leave that you're actually entitled to. **R:** Can you say a bit more about that? **P:**So often, you know I will work extra hours so. I will try and fit as much as I can into my days and then often that isn't enough so I'm working you know after the children have gone to bed I'm doing notes or doing admin or sometimes even on my day off I'm you know. But then also I'm spending a lot of thinking time outside of it as well, and then you	Function of wellbeing is to support the system, not the individual.
Don't cost the NHS money. Seen as a burden?		Made to feel like a burden to the NHS
Told how much NHS is paying for training		
Grateful		
Feeling of owing the NHS		Feeling indebted to NHS for training opportunity
Guilt		
Aren't many who try to defraud NHS		Positive identity with other NHS staff
Goes above and beyond time and resources		NHS staff go above and beyond in their jobs but are made to feel guilty for prioritising self
It's – wellbeing?		
Made to feel guilty for taking leave.		
Often works extra hours.		Job demands are too big to complete in working hours
Try to fit everything into her day.		

Appendix J: Personal Experiential Themes Manual Sorting

Appendix K: Personal Experiential Themes Participant 4

Personal Experiential Theme	Subtheme	Experiential Statements	Quotes
Course providers minimise the importance of well-being.	Well-being is not considered a priority.	Course did not actively promote well-being.	*'I don't think many of us really felt that they did a lot in terms of promoting well-being[…] I think it was quite good at normalising stress, but I don't think it offered many solutions to it'*
		Trainee felt their well-being was dismissed.	*'I felt there was an implicit kind of message if you have to get on with it, don't complain too much'*
		Well-being not experienced as a priority.	*'I just felt like it wasn't really a priority.'*
	Well-being is deprioritised through a lack of discussion.	Lack of discussion on well-being was suggestive of the course approach to well-being.	*It's interesting because I was thinking about 'did we ever have any lectures or seminars specifically about well-being', and I honestly can't remember having any specific lectures on that[…]I think that says a lot in itself about how important they considered well-being to be.'*
		Lack of discussion about well-being led to not prioritising well-being.	*'I think there were the generic statements about they will support there if people want it but it wasn't really something*

		that was spoken about a lot in terms of how are we doing and so it just got pushed to the bottom of the list'
	Lack of discussion about well-being may have negatively impacted well-being.	*'There was never any explicit messages of you need to stop and take stock and look after yourself during. I think had I done that, I might have come out of training in a slightly better place'*
Training is a process of surviving, not thriving.	Training became about surviving the course at any cost.	*'I think by the end of the course, certainly going into third year, it felt like a survival exercise you just need to get through to the end it doesn't have to be good it doesn't have to be pretty we just have to get through it and get out the other side.'*
	Feeling tested by experience, and aiming to just survive it.	*'I think the general sense from people with my cohort that I spent the most time with was that this was almost like a test. If you can survive clinical training then you can survive anything that the job throws at you kind of thing.'*
	Well-being approach was to keep pushing through until the end.	*'It felt like we just needed to keep our head down and keep going with it and then we'd be out the other side and it wouldn't matter anymore'*
	Finishing the course will improve well-being.	*'And I think it was almost that same pattern that we were telling ourselves that once were qualified, it'll be better it'll all be OK once we get through the course.'*

		Surviving training takes priority over well-being.	*'I think that probably emphasised again that you're here to do a job that's what we're interested in is getting you through this course and if we can do that with you as a relatively functioning human at the end of it then that's great but that's not essential.'*
		Other cohorts acknowledge the challenges and offer support	*'I wonder if a bit of that came from the cohorts that went before us as well, not necessarily in a negative way that more in a this is shit, but you need to keep going and will support you if you can.'*
The unhelpful impact of the DclinPsy culture.	Gratitude invalidates distress.	Gratitude for your place should overpower any complaints.	*'You are fortunate to be here, you're lucky to have your place on your course with all this funding. Just be quiet get on with it and don't cause too much trouble. It was never explicitly said like that, but I think that generally was a sense that I got a little bit.'*
		Expectation to feel indebted for the opportunity silences distress or challenges.	*'there are some things that are really positive about it, but I think it does perpetuate this you should be grateful to be here mentality I really felt that that was an implicit message that you shouldn't complain too much 'cause we're doing you a favour by letting you be here and funding this course for you'*

	Pressure and stressors of application are carried into training.	Stressed when starting the course due to the application process	*'I think a lot of people find the application process quite stressful that kind of churning you're constantly to apply, in the middle of applying or taking the feedback on board, being unsuccessful in getting ready to apply again. So, it's a real cycle, and there isn't really a break from it so that can be quite stressful. And then you're starting the course off the back of that'*
		Feeling pressure to continue performing after application	*'I think particularly there's a tendency before you get on the course for a lot of people to see it as the Holy Grail of once I get a place on the course everything will be OK. I just need to get on the course. And then I think sometimes you get there, and you realise, oh now I have actually to complete this'*
Connection with others can support and maintain well-being.	Validation and Normalising through shared experience with cohort.	Peer relationships helped to normalise the experienced challenges.	*'I guess the support of my cohort was really important and that really kept me going and helped me cope with it 'cause I think it was a very normalising part of that which is helpful'*
		Peer connections provided empathy and validation.	*'So I think that possibly makes qualification a tricky time because I think it's probably quite a vulnerable time for a lot of psychologists[…] my colleagues empathise with that and normalise that'*
		Peer relationships help to make sense of course challenges.	*'I think the general sense from people with my cohort that I spent the most time with was that this was almost like a test.'*

		Peer Relationships were supportive.	*'I had a good cohort I felt very well supported by them'*
	Support through connection with local supervisors.	Supervisors external to the university were important sources of support.	*'Local support was always very good I always had very good service supervisors locally and I was always very grateful for that because I think they kept me going.'*
		External supervisor was approachable and helped the trainee to navigate challenges.	*'My local supervisors were always very very good, one of my supervisors was also my line manager through a lot of training as she was always very supportive, and I could go to her with things. And she helped me navigate some of those difficulties with the academic tutor as well stop I think the local support was very good the support from the university not so much'*
		Protected from additional stressors by placement supervisor.	*'I think I had good supervisors who tried to protect me in terms of, for example my child psychology placement the team was very dysfunctional there was a lot of change but I didn't feel impacted by that because my supervisor was careful to say let's focus on your caseload'*
Feeling unprepared for the challenges of post-qualification.		Unhelpful shielding from the challenges of NHS	*'I feel like there was like maybe supervisors wanted to tend to give a good show of their team in the department and not let you see behind the curtain because we don't want you to see the mess by behind here […] but also it insulates you from that learning about how to navigate that because that's waiting for*

		you and qualified life whether you like it or not and there's less people there to isolate you from it.'
	Unclear post-qualification expectations left trainee feeling vulnerable and unable to advocate for themselves.	*'I think another thing that contributed to the burnout, which the course could have prepared me for, but they didn't, was just knowing what the role should look like. I have the impression that if I was going to my managers and saying this is too much, I can't do this then that's me saying I can't do my job because they wouldn't give me these things to do unless they thought that was part of my job as a psychologist… The NHS is awkward and clunky, and it doesn't always work, and I think you need to be able to point that out and stand up for yourself within that, and that's really important for your well-being, and I don't think the course really prepared, us for that at all.'*
	Feeling upnrepared came from being protected from the challenges of qualified life.	*'I think that protective part is helpful in the moment, but actually, it doesn't prepare you well for managing qualified life'*
	Unhelpful habits were learned in training and became unhelpful habits post-qualification	*'I feel like a lot of the unhelpful things I learned during training, just rolled over into post-qualification and became a normal part of my working habits and that obviously didn't help in terms of feeling able to like manage once I was qualified'*

Appendix L: IPA Working Group Meeting Log

Text in red has been added after the log entry to help contextualise the entries for the readers or protect the identity of other members.

Date	Topics Discussed / Extracts shared	Reflections / Actions
11/11/2023	Initial Meeting. [Group Facilitator] explained how IPA working groups can be used, and the group discussed what would be the most useful way to set this up. Agreed that it would be helpful for us all to bring transcripts at different stages of analysis (coding, experiential statements, PETs and GETs if timeline allows). I had been playing around with different ways of accessing the three levels of coding, i.e whether these should be done individually or at the same time. Discussed this with the group. [Other member] shared two pages of coding from their participant.	Really noticed that I was looking for confirmation that I was doing IPA the 'right' way today, I need to try and move away from this, there is flexibility in the process as long as that is grounded in the IPA principles. – I imagine confidence here comes with greate experience. Talking with the group members I realised how much of the IPA principles I have started to embody in my approach to even thinking about analysis. In regards to coding – am going to be flexible with this and start by identifying descriptive, linguisting and interpretive codes individually, and hope that as I become

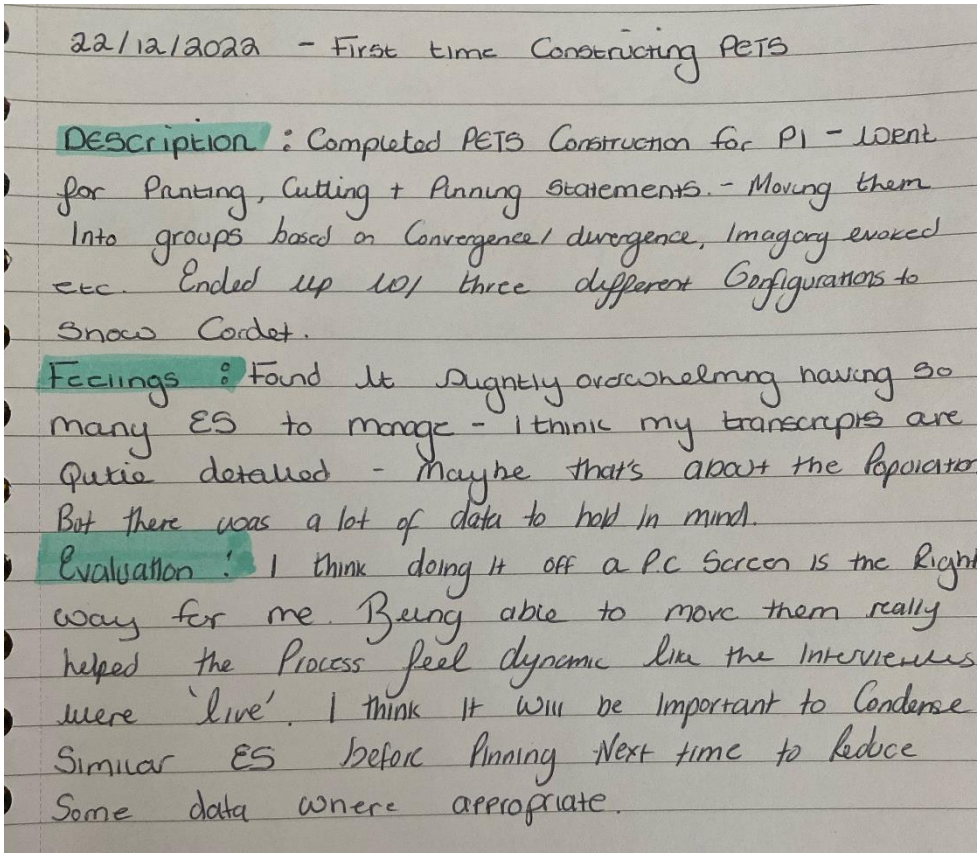
		more confident, my process may evolve - or not. Looking at [Other member's] coding really highlighted the impact of the researchers meaning-making and I could see the value of me not being familiar with the participant group, but also the interpretive value that came from [Other member] having expereince in the area- interesting to think about with [Supervisor]
18/11/2023	Today I brought the first 4 pages of the transcript from my first interview to share with the group. We looked at the different levels of coding. Feedback from [Group Facillitator] that some of the descripting codes were too interpretive in nature.	It was really helpful to talk this through with the group. I feel like I was over complicating the coding stage, and that was leading to the over interpretation – I did also wonder if some of this was coming from my closeness to the data, although the other members seemed to also be over interpretive in their coding and they had lesser or no relationships to their phenomenon – talk about with

		[Supervisor and Consultant Researcher]. Plan is to go back and recode this transcript, really focus on just what is the participant saying for the descrptive codes, it is just a sumuary of content.
29/11/2023	Attended IPA group – [Other Member] Sharing coding from early trascript. Discussion about ES (experential statements) using example from Smith et al., 2022 IPA book. [Other Member] Sharing ES – group reflected the interpretation felt quite far from the original text.	Something overwhelming about moving from the individual coes to the ES. Ican see from examples that people often compose the ES on a separate document, i think I'll do mine on the coded transcript to that I can keep the origninal data close, and keep checking that the ES is capturing the text. Looking at [Other Member's] there is something very important about capturing the language used by the participant throughout the analysis stages. I think moving too far from this language too early on can move into a higher level of interpretation that is needed at this point? – that's how I

		make sense of it from my reading but good to check with [Group Facillitator] next time and [Supervisor/Consultant]
13/12/2023	Group met to discuss the PETs stage, share understanding of the process and explore ways of doing this e.g using computer softwear or completing by hand, how to start the process, different ways that participants have talked or expressed meaning-making e.g a feeling that comes across to the researcher, strong imagary etc.	Think all of this through with [supervisor]- but I think my preference would be to do this manually. I would rather be able to physically move the statemements around into different potential PETs and take pictures of different combinations – can could then take those to [Supervision, Consultant] and IPA group for discussion. Does it matter if some are done manually and others are done electronically – i.e using word (need to check this out)
23/12/2023	[Other member] and I met today, as other members were not available. We both shared PETs for one participant and reviewed the original text alongside the quotes, codes, and EP	Really helpful to get another perspective on these outside of the supervisory team. Although I am very aware that [other member] is also a trainee and has a lived expereince of the phenomenon. It's going to be really important for

	[consultant] to spend a good amount of time with me around PETs and GETs to really allow for space to think about these from different perspectives and unpack the process. – Speak with [supervisor] about this and make sure there is scope for [consultant] to be involved in a big way here.

Appendix M: Excerpt from Reflective Journal: Gibbs Reflective Cycle

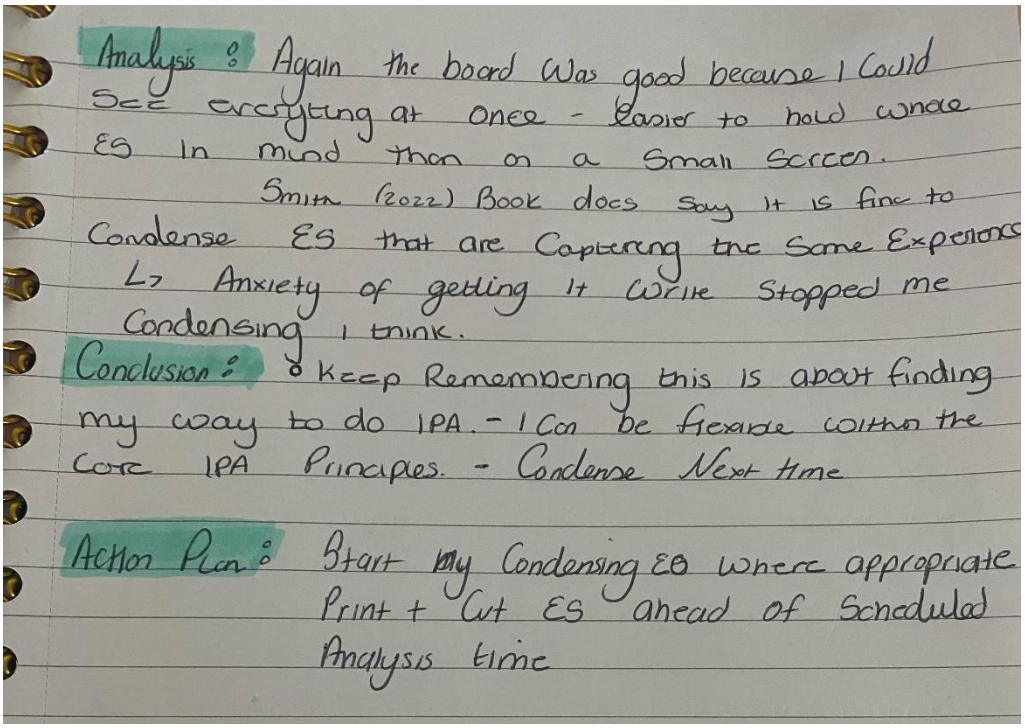


22/12/2022 - First time Constructing PETS

Description: Completed PETS Construction for P1 - 10ent for Printing, Cutting + Pinning statements. - Moving them into groups based on Convergence/ divergence, Imagery evoked etc. Ended up w/ three different Configurations to show Cordet.

Feelings: Found it slightly overwhelming having so many ES to manage - I think my transcripts are quite detailed - Maybe that's about the Population But there was a lot of data to hold in mind.

Evaluation: I think doing it off a P.C Screen is the Right way for me. Being able to move them really helped the Process feel dynamic like the Interviewers were 'live'. I think it will be important to Condense Similar ES before Pinning Next time to Reduce Some data where appropriate.



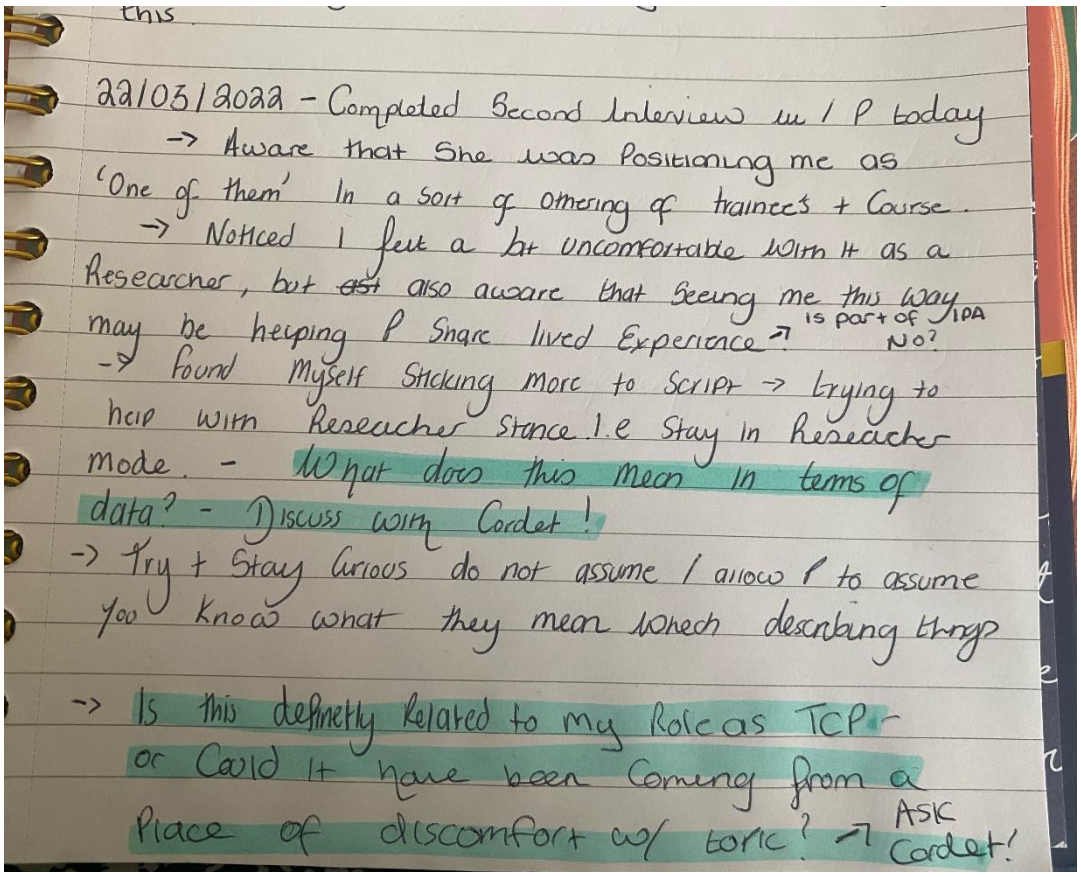
Analysis: Again the board was good because I could see everything at once - Easier to hold whole ES in mind than on a Small Screen.

Smith (2022) Book does say it is fine to Condense ES that are Capturing the Same Experience
↳ Anxiety of getting it write Stopped me Condensing I think.

Conclusion: Keep Remembering this is about finding my way to do IPA. - I can be flexible within the core IPA Principles. - Condense Next time

Action Plan: Start by Condensing ES where appropriate Print + Cut ES ahead of Scheduled Analysis time

Appendix N: Excerpt from Reflective Journal



this.

22/03/2022 - Completed Second Interview w/ P today
-> Aware that She was Positioning me as 'One of them' In a sort of othering of trainees + Course.
-> Noticed I felt a bit uncomfortable with it as a Researcher, but ~~as~~ also aware that Seeing me this way may be helping P Share lived Experience → is part of IPA No?
-> found Myself Sticking more to Script → trying to help with Researcher Stance. I.e Stay in Researcher mode. - What does this mean in terms of data? - Discuss with Cordet!
-> Try + Stay Curious do not assume / allow / to assume you know what they mean when describing things

-> Is this definetly Related to my Role as TCP - or Could it have been Coming from a Place of discomfort w/ topic? → ASK Cordet!

Appendix O: **Reflexivity Statement**

Description of the Researcher

I am a 29-year-old white, British, neurodiverse female currently completing the Clinical Psychology Doctoral Training Programme in the Southwest of England. I conducted the current research in partial fulfilment of my doctoral qualification.

Relationship to the Phenomenon of Interest

As a Trainee Clinical Psychologist, I have experience engaging in a doctorate in clinical psychology programme and learning about well-being throughout this process. My interest in healthcare workers' well-being, specifically how they learn to manage their well-being, pre-dates my journey in clinical psychology. I first discovered my interest when working as a Care Coordinator in a specialist community mental health team. I was responsible for reflective practice and clinical supervision of often newly qualified, multi-disciplinary (MDT) staff members who had completed various training programmes. Each had their journey relating to well-being. As I moved into the field of clinical psychology, I became increasingly interested in the well-being and learning about well-being in this population, as there seemed to be a greater focus on well-being amongst my psychology colleagues than my MDT colleagues. My interest in this topic is inextricably linked with my involvement in clinical psychology.

In conversations with my MDT colleagues and supervisee, I was often most struck by the individual difference in people's experience of the same workplace, stressors, and job demands. What was for one person a significant threat to their well-being was for another the reason why their job sustained

their well-being at work. It highlighted that understanding this issue of well-being and learning about well-being was not a prescriptive experience, with a set number of outcomes but rather a wholly individualised experience based on how individuals make sense of the challenges and demands of their working life. This way of understanding the topic area drew me towards an IPA approach allowing me to champion the individual lived experience in my exploration for greater understanding.

An essential aspect of my reflexivity journey throughout this research has been understanding my sense-making experiences while considering my unique and, frankly, very close relationship to well-being and clinical psychology. Very early in the research process, my supervisors and I were having regular discussions about how vital reflexivity will be in enabling me to produce a credible piece of research. Throughout the process, I have tried hard to position myself as a researcher rather than allowing myself to fall into the position of fellow CP or clinician to provide some space and appropriate distance between my experiences and my participants' experiences. Maintaining this separation was particularly challenging through the interview and analysis stages, where participants tended to view me firstly as a trainee rather than a researcher. I noticed myself sticking more firmly to the interview schedule in earlier sessions to give myself a framework within which I could re-position myself as a researcher for the participant and myself. As time passed, I felt more able, through growing confidence, to manage that positioning without relying on the interview schedule for structure.

Many participants explained that this was the first time they had really talked about their experiences of learning about well-being rather than their

well-being itself. During the interviews, I was struck by just how emotive the participants found the experience of talking about their learning experiences and much sense-making participants were doing live in the 'room'.

Shifting Perspectives

Reflexivity is an ongoing process; there is no desired end goal. This was particularly noticeable for me in terms of the shifting and changing of my views throughout the project. Responsibility is an interesting discussion within employee well-being, with some believing individual well-being is the responsibility of the healthcare employee, whilst others believe it is the employer's responsibility. At the start of the process, I was aware that I leaned more towards the employer holding responsibility. Still, as I engaged in data collection and had several lengthy conversations with supervisors, consultants etc., I found myself moving towards the viewpoint that well-being is an individual responsibility. Over time, I have settled into a viewpoint that is more closely aligned with my clinical practice, that is to say, that organisations hold a responsibility to their employees, much like a duty of care. Still, individuals must take ownership of their own well-being. I imagine that when I look back on this research in two, 10 or 30 years, my opinion will have shifted several times over, as is the ongoing nature of the reflexive journey.

Appendix P: Group Experiential Themes Development

Group Experiential Theme (Number of Participants Experiencing the Theme)	Participants who Experienced this	Subthemes (Number of Participants Experiencing the Theme)
1. Implicit Messages about well-being (10)	#1 #2 #3 #4 #5 #6 #8 #9 #10 #11	
2. Well-being is not Prioritised (9)	#1 #2 #3 #4 #5 #6 #7 #9 #10	a) Training requirements are more important than your well-being (6) b) Expectations to prioritise workload over work-life balance (7)
3. Connection Maintains Well-being (9)	#1 #2 #4 #5 #6 #7 #8 #10 #11	a) Validation through shared experience with the cohort (9) b) Feeling supported by supervisors (6)
4. Feeling inadequately prepared for post-qualification life (8)	#1 #2 #3 #4 #6 #7 #8 #10	a) Missed opportunities for learning about positive well-being management (6) b) Counterproductive Learning Experiences (5)

Appendix Q: Target Journal Submission Guidelines

British Journal of Clinical Psychology

Author Guidelines

Sections

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

New submissions should be made via the **Research Exchange submission portal**. You may check the status of your submission at any time by logging on to submission.wiley.com and clicking the "My Submissions" button. For technical help with the submission system, please review our **FAQs** or contact **submissionhelp@wiley.com**.

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By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at **https://authorservices.wiley.com/statements/data-protection-policy.html**.

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This journal will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

The *British Journal of Clinical Psychology* publishes original research, both empirical and theoretical, on all aspects of clinical psychology:

- clinical and abnormal psychology featuring descriptive or experimental studies
- aetiology, assessment and treatment of the whole range of psychological disorders irrespective of age group and setting
- biological influences on individual behaviour
- studies of psychological interventions and treatment on individuals, dyads, families and groups

For specific submission requirements, **read** the Author Guidelines.

The Journal is catholic with respect to the range of theories and methods used to answer substantive scientific problems. Studies of samples with no current psychological disorder will only be considered if they have a direct bearing on clinical theory or practice.

The following types of paper are invited:

- papers reporting original empirical investigations;
- theoretical papers, provided that these are sufficiently related to empirical data;
- review articles, which need not be exhaustive, but which should give an interpretation of the state of research in a given field and, where appropriate, identify its clinical implications;
- Brief Reports and Comments.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Papers describing quantitative research should be no more than 5000 words (excluding the abstract, reference list, tables and figures). Papers describing qualitative research (including reviews with qualitative analyses) should be no more than 6000 words (including quotes, whether in the text or in tables, but excluding the abstract, tables, figures and references). Brief reports should not exceed 2000 words and should have no more than one table or figure. Any papers that are over this word limit will be returned to the authors. Appendices are included in the word limit; however online appendices are not included.

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Refer to the separate guidelines for **Registered Reports**.

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

4. PREPARING THE SUBMISSION

Free Format Submission

British Journal of Clinical Psychology now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer (If you do submit separate files, we encourage you to also include your figures within the main document to make

it easier for editors and reviewers to read your manuscript, but this is not compulsory). All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.

- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

Important: the journal operates a double-anonymous peer review policy. Anonymise your manuscript and prepare a separate title page containing author details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

- An ORCID ID, freely available at https://orcid.org. *(Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)*

To submit, login at **https://wiley.atyponrex.com/journal/BJC** and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

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You may like to use **this template** for your title page. The title page should contain**:**

i. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
ii. A short running title of less than 40 characters;

iii. The full names of the authors;
iv. The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
v. Abstract;
vi. Keywords
vii. Data availability statement (see Data Sharing and Data Accessibility Policy);
viii. Acknowledgments.

Author Contributions

For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our **Author Services** site.

Abstract

Please provide a structured abstract under the headings: Objectives, Methods, Results, Conclusions. For Articles, the abstract should not exceed 250 words. For Brief Reports, abstracts should not exceed 120 words.

Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

Keywords

Provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet points, following the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professional practice.

Main Text File

As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors.
Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation "Main Document – LaTeX .tex File" on upload. When submitting a LaTex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as "Main Document - LaTeX PDF." All supporting files that are referred to in the LaTex Main Document should be uploaded as a "LaTeX Supplementary File."

LaTex Guidelines for Post-Acceptance:

Please check that you have supplied the following files for typesetting post-acceptance:

- PDF of the finalized source manuscript files compiled without any errors.
- The LaTeX source code files (text, figure captions, and tables, preferably in a single file), BibTex files (if used), any associated packages/files along with all other files needed for compiling without any errors. This is particularly important if authors have used any LaTeX style or class files, bibliography files (.bbl, .bst. .blg) or packages apart from those used in the NJD LaTex Template class file.
- Electronic graphics files for the illustrations in Encapsulated PostScript (EPS), PDF or TIFF format. Authors are requested not to create figures using LaTeX codes.

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations;
- Abstract structured (objectives/methods/results/conclusions);
- Up to seven keywords;
- Practitioner Points: Authors will need to provide no more than 2-4 bullet points, written with the practitioner in mind, that summarize the key messages of their paper to be published with their article;
- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;
- References;

- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below).

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors. Do not mention the authors' names or affiliations and always refer to any previous work in the third person.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

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For guidelines on editorial style, please consult the **APA Publication Manual** published by the American Psychological Association. The following points provide general advice on formatting and style.

- **Language:** Authors must avoid the use of sexist or any other discriminatory language.
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- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

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Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to recognised research reporting standards.

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The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company

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Funding

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