Quality of Life and experiences of psychological distress and burnout among Aotearoa New Zealand psychologists

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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Marty Blayney

Dated: 27/01/22

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Our amazing cohort. If this is what the next generation of psychologists looks like, I feel very hopeful.

ABSTRACT

This study aims to explore quality of life, psychological distress and experiences of burnout among practising psychologists in an Aotearoa New Zealand context.

While a large amount of research has examined the experiences of health professionals internationally, little research has been undertaken in Aotearoa New Zealand, despite high turnover numbers and anecdotal reports of distress among psychologists. Identifying to what degree psychologists are experiencing psychological distress and burnout symptoms, what they perceive as the causative factors, and what techniques they personally use to protect against psychological distress and burnout is crucial information to understand and retain the mental health services offered within New Zealand.

This study utilises a mixed methods approach. A cross-sectional online survey of Aotearoa New Zealand practising psychologists was employed, assessing Professional Quality of Life, burnout and psychological distress using the DASS-21 and ProQOL-5 measures. A statistical analysis of these measures was undertaken, followed by an Interpretative Phenomenological Analysis (IPA) of open ended qualitative questions, which explored how psychologists viewed and interacted with burnout as a concept, as well as what they perceived to be the causative factors of psychologist burnout. An additional explanatory-sequential mixed-methods approach was utilised, exploring the thematic content differences between two cohorts, those experiencing the highest and lowest degrees of psychological distress within the survey. Results from each technique were contrasted to develop an overall picture of quality of life, psychological distress and experiences of burnout within Aotearoa New Zealand practicing psychologists.

Psychologists described their frustrations at working within the mental health system in Aotearoa New Zealand, due to issues with high case loads, professional isolation, and difficulties with management. No clinically significant levels of burnout were measured in this sample, however a large cohort were seen to be at-risk of developing burnout. The study suggests that burnout will

continue to be a major issue impacting psychologists, unless increases to the number of practicing staff and potentially systemic changes are undertaken.

CHAPTER 1: INTRODUCTION

Professional quality of life for healthcare professionals

Since the 20th Century, psychological ill-health among healthcare professionals and psychological barriers that hinder their ability to successfully perform in the workplace have been identified as crucial aspects of work-life that warrant investigation. Initial inquiries focused on the impact of anxiety and countertransference on psychotherapists and how these affected client outcomes, however by the 1970s a new term emerged to describe the phenomenon: burnout (Bandura, 1956; Freudenberger, 1974; Maslach & Pines, 1977; Yulis & Kieser, 1968). Based on reports of healthcare professionals' experiences of gradual exhaustion and inefficacy in the workplace (Freudenberger, 1974), early conceptions of professional quality of life focused exclusively on negative aspects of the work experience (Larsen & Stamm, 2008). By the 1990s, studies of the professional wellbeing of healthcare professionals' began to look at factors other than burnout, including the effects of working with traumatised clients, known as vicarious trauma (McCann & Pearlman, 1990), and the reduced ability to empathise with clients, which was termed compassion fatigue (Figley, 1995).

Professional quality of life is a concept that was introduced when investigations began to consider positive factors that had the ability to balance or mitigate negative work experiences (Larsen & Stamm, 2008; Stamm, 2010), including factors such as posttraumatic growth (Tedeschi & Calhoun, 1996; Manning-Jones et al., 2016) and compassion satisfaction (Stamm, 2002). The term "quality of life" has a history in literature dating back to the 1950s used in terms of human development, it has gained popularity in more recent years in terms of an individual's wellbeing, broadening earlier concepts such as happiness or welfare (Serinkan & Kaymakçi, 2013). Scales for measuring job satisfaction in a psychological context have existed since 1951 (Brayfield & Rothe, 1951; Thompson & Phua, 2012), however these measures focus on generalised aspects of the workplace, and not the specific experiences of healthcare professionals interacting with clients.

In 2005, Stamm created the Professional Quality of Life Scale (ProQOL); a self-report scale that could measure both positive and negative factors involved in professional quality of life. After several iterations, the 5th Edition of ProQOL measures overall professional quality of life a three-factor model: compassion satisfaction, representing the pleasure of work and protective aspects, and two sub-scales of burnout and secondary traumatic stress (STS), which together are components of compassion fatigue (Stamm, 2010). ProQOL has been widely assessed among healthcare workers, including mental healthcare professionals in general (Sprang et al., 2007), trauma-specialising therapists (Sodeke-Gregson et al., 2013) and social workers (Bloomquist et al., 2016).

A more in-depth discussion of burnout as a concept is presented later in this dissertation, however STS is conceptualised as symptoms resembling post-traumatic stress disorder (PTSD) which result from exposure to people suffering the effect of trauma (Cieslak et al., 2014). Compassion fatigue, burnout, secondary traumatic stress and vicarious traumatisation can often be used in interchangeable and overlapping ways within research contexts, however all of these factors represent distinct concepts (Baird & Kracen, 2006; Cieslak et al., 2014; Nimmo & Huggard, 2013; Thomas & Wilson, 2004). STS involves rapid onset symptoms of intrusive images, fear, difficulty sleeping and avoidance related to the topic involved in the trauma; none of which are present in typical burnout symptoms. Trauma therapists may experience more symptoms of STS than burnout, compared to non-trauma specialising therapists (Sodeke-Gregson et al., 2013).

For healthcare professionals, many factors that impact professional quality of life have been identified as risk factors, including a lack of ongoing training, high caseload demands, limited access to supervision, an unsupportive work environment, poor work environment safety, high number of trauma clients, professional isolation, unsupportive or non-existent social networks, a personal history of trauma, insufficient income, poor work-life balance, unbalanced caseloads and poor work satisfaction (Larsen & Stamm, 2008). Burnout is strongly correlated with overall psychological

distress symptoms (Goldhagen et al., 2015), but is conceptually distinct in its focus on work-related experiences (Maslach & Leiter, 2017).

Psychological distress and healthcare professionals

Psychological distress is a common construct within mental health literature, used as a testable concept to measure the overall psychological wellbeing of populations (Drapeau et al., 2012). The term is often applied to symptoms such as depression, generalised anxiety and behavioural issues representing negative aspects of wellbeing (Drapeau et al., 2012; Mirowsky & Ross, 2002), Distress has a variety of definitions, however the most consistent definitions involve an emotional discomfort experienced by a person in response to a stressor or demand, and the negative outcomes associated with this experience (Ridner, 2004). Psychological distress is often used in psychology literature as a concept to judge the severity of disorders such as depression and anxiety (Phillips, 2009).

A common measure for tracking major aspects of psychological distress is the Depression, Anxiety, and Stress Scale (DASS-21) (Lovibond & Lovibond, 1995), which measures anxiety, depression and stress as different dimensions of distress (Henry & Crawford, 2005). While the three dimensions can be combined as a valid single-factor measure, each subscale also represents a distinct construct of psychological distress (Henry & Crawford, 2005; Lee, 2019).

Untreated distress among psychologists is associated with the loss of the ability to practice therapy effectively (Barnett et al., 2007; Sherman & Thelen, 1998). Psychological distress among healthcare professions as measured by the DASS-21 has been shown to highly correlate to a variety of burnout measures (Creedy et al., 2017; Goldhagen et al., 2015; Talaee et al., 2020), and the individual subscales correlate highly with the ProQOL measures of compassion satisfaction, STS and burnout (Duarte, 2017). Among mental health professionals, high psychological distress has been associated with dissatisfaction in salary (Saquib et al., 2019), lack of career opportunities (Tran et al., 2019), high workload (Elbay et al., 2020; Saquib et al., 2019), increased working hours (Elbay et al.,

2020), poor teamwork (Saquib et al., 2019; Tran et al., 2019), less time working in their profession (Elbay et al., 2020; Shahruddin et al., 2016; Tran et al., 2019), perceived bullying (Shahruddin et al., 2016) and using fewer self-care strategies (Pinho et al., 2021).

Burnout and healthcare professionals

Burnout as a psychological construct was first used in scientific literature by Freudenberger (1974) to describe a state of exhaustion impairing cognition and judgement that he identified in his co-workers and himself working at a free clinic in the United States. Since the advent of the Maslach Burnout Inventory (MBI) in 1981, burnout has been conceptualised in terms of three dimensions: emotional exhaustion (i.e. the feeling of being mentally depleted or overextended), depersonalisation (originally "cynicism" – a lack of feeling towards clients), and sense of inefficacy/lack of personal achievement (Awa et al., 2010; Maslach, 2003; Maslach & Jackson, 1981). In addition to these dimensions, burnout is conceptualised as a phenomenon with a gradual onset, which is associated with workplaces (Awa et al., 2010), and much literature focuses on burnout within "person centred" roles such as medical professionals and teachers, as these were the groups first identified in the literature as experiencing burnout. As research has developed on the subject, the phenomenon has been identified within a much wider range of professions (Demerouti et al., 2001; Maslach & Jackson, 1981; Maslach & Leiter, 2017), and while further measures and conceptions have been developed, the Maslach model has widely influenced the conceptualisation of burnout (Schaufeli et al., 2020; Shoman et al., 2021). The ProQOL Burnout subscale focuses on a wider set of symptoms, with items focusing on poor wellbeing, negative attitudes, overwork and a lack of self-acceptance, compared to the MBI and other scales' tendency to focus on exhaustion symptoms (Cieslak et al., 2014). Despite this, the three factors of the MBI highly correlate with the ProQOL burnout subscale (Erkorkmaz et al., 2018; Patel et al., 2017).

Burnout is not considered a psychiatric diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). The manual describes burnout as a culturally-bound

syndrome, however offers no insight and discussion of the concept (APA, 2013). The 11th edition of the International Classification of Diseases (ICD-11) defines burnout as an "occupational phenomenon" separate from psychological conditions, and includes a description that matches the three-dimension model found in burnout literature. The ICD-11 emphasises that the syndrome occurs in employment-contexts, and excludes its use in other life circumstances, while listing mood disorders, anxiety disorders and adjustment disorder as exclusions for meeting this definition (World Health Organisation, 2019).

Psychological literature has identified burnout as a separate to exhaustion (Schaufeli et al., 2009), and it can be differentiated from general job stress, due to the emotional responses of workplace cynicism and self-inefficacy not present in job stress (Maslach, 2003). The primary symptoms of major depression, anhedonia and depressed mood, have been demonstrated to highly correlate with the emotional exhaustion and depersonalisation factors of burnout (Bianchi et al., 2015). Burnout appears to be inter-related but distinctive from depression with an unclear directionality (i.e. if burnout symptoms lead to depressive symptoms, visa versa, or if a third factor influences the presence of both; Koutsimani et al., 2019; Tóth-Király et al., 2021).

There is no consistent definition for what constitutes a distinct case of burnout (Eckleberry-Hunt et al., 2018). Many psychometric measures have historically defined burnout through arbitrary cut-off scores; assuming that the highest scoring groups are experiencing the worst burnout symptoms (Maslach & Leiter, 2017), while the ProQOL-5 burnout subscale recommend its use as continuous scale (Stamm, 2010), Some researchers do not specifically refer to "burnout" as an independent concept at all, instead investigating factors such as overwork and exhaustion (Eckleberry-Hunt et al., 2018). Difficulties in establishing non-arbitrary cut-off scores began to be highlighted in the literature (Doulougeri et al., 2016; Leiter & Maslach, 2016), and by the 4th Edition of the MBI in 2016, the authors removed scales and explicit cut-off scores entirely.

Measuring burnout with continuous scale is conceptually congruent with Hobfoll (1989)'s Conservation of Resources (COR) model, which conceptualises burnout and stress as a depletion of resources experienced gradually (Best et al., 2005). This model proposes that people are motivated to protect current resources and acquire new resources, and that burnout is a response to losing job resources (Halbesleben et al., 2014). The COR model is one of the two prevailing theories explaining burnout, while the other, the Jobs Demands Resources Model (JD-R), theorises the exhaustion component of burnout is explained by high job demands, such as time pressure and workload, while the depersonalisation aspect is explained by a lack of job resources, such as peer feedback and salary (McCormack et al., 2018).

Psychologists' experiences of psychological distress and burnout

Burnout among psychologists is a major issue, affecting an estimated 20-67% of practicing clinicians (O'Connor et al., 2018; Morse et al., 2012). Increased experience of burnout symptoms for mental health practitioners is associated with poorer patient outcomes overall (Delgadillo et al., 2018), and burnout symptoms among practicing psychologists are associated with a range of negative outcomes, including a deterioration in the level of care, high job turnover, developing a generalised negative view of others and clients disengaging from treatment (Evans et al., 2006; Maslach & Jackson, 1981; Rupert et al., 2015; Paris & Hoge, 2010; Yang & Hayes, 2020). Research specifically looking at practicing psychologist burnout has been undertaken since Ackerley et al. in 1988 (Rupert & Morgan, 2005), and practicing psychologists report some of the highest level of emotional exhaustion among mental health professionals globally (Dreison et al., 2018).

Studies of psychologists and other medical professionals have identified several factors that influence burnout experience and severity, including organisational factors, client factors, and personal factors. Of these, personal factors correlate with burnout much more than organisational factors (Simpson et al., 2019). In terms of demographics, some studies have identified women in

agency settings experiencing more professional burnout (however this finding has had replication issues; Rupert & Morgan, 2005; Rupert et al., 2009).

Organisational factors that predict burnout include higher job demands with few resources, lack of control in their job, longer hours, lack of rewards such as pay or acknowledgement, poor community, lack of job fairness and ethical conflicts (Simpson et al., 2019; Paris & Hoge, 2010; Rupert & Morgan, 2005; Yang & Hayes, 2020). In terms of patients themselves, working with chronic or complex patients (Simpson et al., 2019) and dealing with more negative client behaviours (i.e. antisocial or inappropriate client behaviours) correlated with higher levels of burnout (Rupert & Morgan, 2005).

Personal factors influencing practicing psychologist burnout include Early Maladaptive Schemas (EMS), i.e. maladaptive core beliefs and behaviours developed early in life (Simpson et al., 2019). The most common of these presenting in therapists include unrelenting standards (i.e. a belief in high standards of behaviour not applied to other people) and self-sacrifice (i.e. the belief that others' needs are much more important than the person's own needs, even in situations where this does not reflect reality), however the schemas correlating highest with burnout were abandonment, mistrust/abuse, and emotional inhibition (Simpson et al., 2019). Personal factors associated with higher likelihood of burnout include low self-esteem, an external locus of control, low mental resilience, and Type A personalities (Maslach & Leiter, 2017). A number of protective factors have also been identified, including peer social support, being a solo practitioner, and age or the number of years' experience in their current job (Rupert & Morgan, 2005; Ballenger-Browning et al., 2011), however this may be a survivor effect (i.e. those who burnt out left the profession and could not be surveyed, while those who had resilience remained; Rupert & Morgan, 2005).

Some strategies that have been proposed to reduce the incidence of burnout among practicing psychologists includes better salaries, opportunities for promotion, routine assessment of psychologists for burnout, and even social events to increase peer support (Schaufeli et al., 2009).

Most research that proposes solutions focuses on methods to reduce negative symptoms of burnout, instead of preventative positive psychology measures (Eckleberry-Hunt et al., 2018), however mindfulness has been proposed as a protective factor for therapists (O'Donovan & May, 2007).

The mental health landscape of New Zealand

Demand for mental health and addiction services in New Zealand has seen significant increases in recent years, alongside major systemic issues such as widespread addiction and persistently high suicide rates, especially among youth (New Zealand Government, 2018). The historical basis for the lack of mental health resources in the country can be linked to the closure of psychiatric hospitals during the latter half of the 20th Century. A culture shift in English-speaking countries towards the community treatment model for mental health led to systemic closures of these hospitals, however no proportionate increase in the number of beds and services eventuated (Allison et al., 2019; Ministry of Health, 2021). The 2018/19 Health Survey noted high levels of psychological distress across New Zealand, especially among women, people aged between 15 and 24, disabled adults, Māori, Pasifika and people living in socioeconomically deprived areas (Ministry of Health, 2021).

In the 2018 *He Ara Oranga* government enquiry, which investigated ways to improve the mental health system, stress, overwork and burnout were identified as factors impacting the wellbeing of the mental health workforce (New Zealand Government, 2018). The 2021 *Kia Manawanui Aotearoa* report, which discusses the long-term pathways to improve mental health, identified developing workforce retention strategies as a short-term goal, while medium-term goals include improving mental health workforce wellbeing, increasing the size of the workforce, facilitating more mental health workers who specialise in complex mental health needs, and expanding supervision and mentoring models. No specific plans to address these issues were discussed in the report.

Recent surveys among general practitioners and psychiatrists revealed several factors which impact their professional quality of life, including a perceived increase of patient complexity, systemic barriers to effective treating patients, administration work overload, high numbers of patients seen daily, minimal assistance, and low perceived levels of peer and managerial support (ASMS, 2021; RNZCGP, 2021). Psychiatrists identified their workloads had become significantly worse in recent years (ASMS, 2021), and many general practitioners reported their plans to leave the workforce within the next 5-10 years, most notably a large cohort who were reaching the age of retirement (RNZCGP, 2021). Clinical psychologists noted extreme demand for services, with waiting times in excess of three months standard for more than half of clinical psychologists surveyed (Skirrow, 2021).

A number of mental health professions have been investigated for symptoms of burnout, including general practitioners (RNZCGP, 2021), nurses (Kalliath & Beck, 2001), psychiatrists (ASMS, 2021; Kumar et al., 2007), resident doctors (Huggard & Dixon, 2011), hospital consultants (Surgenor et al., 2009) and counsellors (Temitope, 2014). High levels of burnout were noted among general practitioners (RNZCGP, 2021), and a lack of supervision and support predicted higher burnout levels for nurses (Kalliath & Beck, 2001). Among hospital consultants, low levels of burnout were detected, however long hours and low job satisfaction were both contributory factors for those who were noted to have high burnout scores (Surgenor et al., 2009). New Zealand counsellors were found to have a high risk for developing STS and burnout, however this was moderated by a high potential to experience compassion satisfaction in their career (Temitope, 2014).

New Zealand psychologists' quality of life

A search of key databases (e.g. SCOPUS, OVID) revealed that only very limited research on psychologist burnout, professional quality of life and psychological distress has been undertaken in a New Zealand context. The largest study, a mixed methods thesis investigating resilience and wellbeing among psychologists (n=224), reported high levels of compassion satisfaction and low

levels of STS and burnout; with ProQOL scores highly correlating to measures of resilience, emotions, vicarious growth, broad-minded coping and self-care, while also strongly negatively correlating with maladaptive coping skills and work stressors (McCormick, 2014). Psychologist self-reports indicated several factors which influenced their professional quality of life, including a systemic lack of discussion of workplace stressors, a need for more self-care and positive psychology interventions, a need for increased therapist-client boundaries to protect psychologists from STS, a need for improved supervision and to address professional isolation, while also recognising a greater need for psychologists to engage in their own personal therapy (McCormick, 2014).

Outside of this thesis, a large international study of burnout and schema included 51 New Zealand clinical or counselling psychologists, and reported that psychologists tended to hold maladaptive schemas of unrelenting standards and self-sacrifice (however results specifically pertaining to New Zealand were not delineated; Simpson et al., 2019). A small amount of literature exists that investigates psychologists' experiences of STS in a New Zealand context. These studies focused on the relationship between STS and vicarious post-traumatic growth (VPTG), involving 72 clinical psychologists who work primarily with trauma (Stapleton, 2017) and 70 psychologists working in any speciality (Manning-Jones et al., 2016). The former study concluded that posttraumatic cognitions were more likely to be experienced by New Zealand trauma-focused psychologists who work longer hours (but not other factors related to the profession), while the latter found that psychologists were the mental health profession least likely to experience negative outcomes due to STS, and most likely to utilise coping strategies.

A single participant of a United Kingdom-based qualitative study discussed their experiences of burnout as a psychologist in a New Zealand specific context (Alfrey, 2014), but otherwise the only perspectives on these three concepts from New Zealand psychologists are tangential studies where burnout is identified as a negative factor. This includes contexts such as an issue for the recruitment and retention of Māori staff in Child and Adolescent Mental Health Services (CAMHS) (n=16)

(Hemopo, 2004), retention of educational psychologists (n=65) (Jimerson et al., 2009) and as a barrier to psychologists' professional competency and ongoing training (n=6) (Brennan, 2018).

Given the increasing demand on mental health services in recent years, the established increasing rates of burnout among other caring professions and anecdotal reports of stress and concern among Aotearoa New Zealand psychologists, the current study aims to consider the reports and perspectives of currently practicing psychologists regarding their professional quality of life and risk of burnout.

Hypotheses

It was hypothesised that psychologists who scored within the severe range of the burnout or psychological distress subscales (i.e. experiencing recent psychological distress or burnout symptoms prior to completing the survey) would deviate from the group experiencing the least degree of psychological distress (normal DASS-21 scores across all three subscales), and that this would influence their qualitative answers when discussing burnout.

CHAPTER 2: METHOD

Participants

Practicing psychologists were chosen as a population to investigate due to the relative consistency of scope of practice – "psychologist" in New Zealand is a legally protected term, meaning someone who uses this term has undergone a consistent lengthy training and accreditation process, with consistent values and practices under the Code of Ethics. Practicing psychologists are also a population who have a pre-existing understanding of burnout, quality of life and psychological distress, both in terms of how these concepts impact their clients' lives, and how they impact their own professional lives.

Of the participants in this study (n = 169), 141 completed the questionnaire, with the remainder missing data and excluded from analysis. This represented an estimated 3.8% of the total

3,676 registered psychologists who held an annual practicing certificate in 2021 (New Zealand Psychologists Board, 2021).

Measures

ProQOL-5

Quality of life and burnout were measured using the 30 item Professional Quality of Life Scale Version 5 (ProQOL-5) (Stamm, 2010). ProQOL-5 measures overall quality of life with three subscales: compassion satisfaction, burnout, and compassion fatigue. The measure uses a 5-point Likert scale analysing symptoms from the past 30 days. The latest ProQOL-5 scale has been shown to be psychometrically valid as a unidimensional measure of professional quality of life (Duarte, 2017; Geoffrion et al., 2019; Hemsworth et al., 2018; Lakatamitou et al., 2021). While compassion satisfaction has been shown to be a distinct factor, some studies have noted construct validity issues within the two compassion fatigue subscales, variously proposing either collapsing the three scales into a bifactor model, or refining of the individual items in the scale to remove confounding artifacts such as if items are positively or negatively worded (Duarte, 2017; Geoffrion et al., 2019; Hemsworth et al., 2018; Samson et al., 2016). The scale has shown consistent reliability across a range of different cultural contexts, across versions published in Chinese (Wu et al., 2014), Spanish (Galiana et al., 2017), Portuguese (Galiana et al., 2017), Latvian (Circenis et al., 2013) and Hebrew (Samson et al., 2016).

ProQOL-5 was used due to its ability to analyse both positive and negative factors impacting overall professional quality of life, something not possible to analyse using burnout-specific tools (Heritage et al., 2018; Geoffrion et al., 2019). The ProQOL-5 burnout subscale significantly correlates with the most commonly used tool for measuring burnout, the MBI (Koutra et al., 2021). The measure correlates with the DASS-21, specifically high ProQOL-5 burnout and compassion fatigue scores/low compassion fatigue to heightened DASS-21 depression, anxiety and stress scores (Duarte, 2017; Fye et al., 2021).

DASS-21

Psychological distress was measured using the 21 item Depression, Anxiety and Stress Scale (DASS-21) (Lovibond & Lovibond, 1995). The DASS-21 measures psychological distress using three subscales: depression, anxiety and stress using a four-point Likert scale, measuring symptoms in the previous week. The scale shows both convergent and divergent validity (Evans et al., 2021; Medvedev et al, 2020; Norton, 2007), and is a valid and reliable tool to assess both depression, anxiety and stress as individual factors, and as an overall measure of psychological distress (Alfonsson et al., 2017; Le et al., 2017). Severe or elevated scores on the DASS-21 overall or on individual scales have shown evidence for their use as effective screening tools to indicate clinical levels of anxiety and depression symptoms (Beaufort et al., 2017; Ng et al., 2007; Randall et al., 2017; Ronk et al., 2013; Tran et al., 2013).

Open questions

Participants were asked two open-ended questions relating to burnout: “From your personal experience, what factors do you think influence psychologist burnout?” and “Do you have any techniques that you use to protect yourself from burnout?”. The two questions were formulated in order to elicit differing perspectives from each psychologist: the former question investigating how psychologists saw burnout as a factor that impacted the profession as a whole, while the latter question investigating how psychologists interacted with the idea of burnout on a personal level. Burnout was chosen as the topic due to its familiar terminology and specific workplace scope, over professional quality of life, which is a term that participants may not have been as familiar with.

Procedure

An online survey was created and administered using the research software Qualtrics. The survey questions formed a part of the Psychologists' Professional Quality of Life and Resilience in Aotearoa New Zealand study (AUTEC reference number 21/184 – approval granted on 16 June 2021), a wider survey of the psychological wellbeing and COVID-19 stress response experienced by New

Zealand practicing psychologists, using validated psychometric tools, self-reported open responses and demographic data.

Volunteer participants were recruited through the New Zealand Psychologists Board (NZPB), the New Zealand College of Clinical Psychologists (NZCCP) and New Zealand psychologist-specific social media. All participants self-identified as registered psychologists from within New Zealand. Participants were encouraged to share with colleagues and acquaintances, to facilitate snowball sampling. Survey responses were anonymous.

Data Analysis

This study utilises an iterative mixed methods approach, involving a three-part design. This approach was chosen as it allowed for the integration of different data perspectives allows for a fuller understanding of psychological phenomena, and facilitated a more flexible and pragmatic approach (Dures et al., 2011; Hanson et al., 2005; Mertens, 2019). A convergent triangulation approach to research is beneficial for finding agreement across different strategies, using strategies that prioritise generalisability, accuracy/control of data and authenticity of context to complement and elaborate understanding (Turner et al., 2017). Raw data was processed and analysed using Microsoft Excel and IBM SPSS Statistics 27.

The initial phase of the study involved a statistical analysis of the DASS-21 and ProQOL-5 subscales, examining the distributions and descriptive statistics reported.

This is followed by a qualitative analysis of two open-ended responses using Interpretative Phenomenological Analysis (IPA) (Biggerstaff & Thompson, 2008; Smith, 1996) to investigate how psychologists conceive of and relate to “burnout” as a concept, a process which involved steps of recursive data familiarisation, coding and subtheme identification (Braun & Clarke, 2013). Themes and concepts were uncovered using an iterative process, where successive reviews of the data refined key themes and insights. Contradictions within the responses were analysed to ascertain if

they were genuine contradictions in how psychologists viewed the subject, or if these contradictions were indicators of a more complex situation than conceived of during the initial stages of analysis.

The third approach involves an explanatory sequential mixed methods design (Fetters et al., 2013; Ivankova et al., 2005), investigating thematic differences in responses seen when comparing two cohorts based on their quantitative responses to the DASS-21 within the survey, the low distress and high distress cohorts. A 15-item codebook was created for question one, and a 35-item codebook for question two. Responses were tallied from each different subgroup, looking for relative frequency differences and unique themes present only in one of the two subgroups.

CHAPTER 3: RESULTS

Participant demographics

Of those surveyed, 90% identified as female and 10% male (no gender diverse or non-binary participants took part in the survey), while 80.7% of participants listed their ethnicity as Pākehā/European New Zealander, 2.8% as Asian, 1.4% Māori, 0.7% Latin American, 2.1% African and 12.8% other. No Pasifika psychologists took part in the survey. This is a significantly greater number of Pākehā/European participants compared to the general New Zealand population (Statistics New Zealand, 2018), however is similar to the results of the *Aotearoa New Zealand Psychology Workforce Survey* (2016), which identified 77% of the workforce as female, 90% Pākehā/European New Zealander, 3% Māori and 1% Pasifika. Māori and Pasifika professional networks for psychologists, He Paiaka Tōtara and Pasifikology, were contacted and invited to participate, however unfortunately did not respond.

Years of psychology practice experience was fairly evenly distributed with the median being 11 to 15 years, however the largest two groups were the 0 to 5 years of experience range and 20+ years (26.2% and 29.8% respectively). Responders' age brackets were evenly distributed between

the age brackets 26 to 55, with fewer responders over 56 and the median age being in the 41 to 45 age bracket.

In terms of scope, clinical psychologists were overrepresented compared to general, counselling or educational (83.7%, 8.5%, 1.4% and 2.1% respectively), compared to 62% indicated in the 2016 survey. 57.1% of responders were based in a major city, with 27.6% psychologists practicing from smaller regional centres, and 7.9% from rural areas of New Zealand. 34.8% of responders worked in a solo-private practice settling, 7.8% in a group private practice and 32.6% at a government-funded organisation, which included institutions such as District Health Boards (DHBs), prisons and Oranga Tamariki.

Of the participants who completed the open questions, 15 qualified to be members of the "high distress" cohort due to scores in the 'severe' and 'extremely severe' range on at least one subscale of the DASS-21, while 73 participants formed the basis for the "low distress" cohort, as this group reported 'normal' range scores across all three depression, anxiety and stress subscales.

ProQOL-5

The mean compassion satisfaction score for participants was 37.56 (SD = 6.31). Means for the burnout score and secondary traumatic stress scores were 24.83 (SD = 5.82) and 20.03 (SD = 5.03) respectively. 72.1% of participants scored within the moderate range for compassion satisfaction, and 22.4% within the high range. 62.8% of participants scored within the moderate range for burnout, however no participants scored higher than the 75th percentile cut-off for high range burnout symptoms (a score of 42 or greater). The majority of participants indicated low secondary traumatic stress scores (72.1%), while 27.9% fell within the moderate range. No participants reported scores within the high range for secondary traumatic stress (42 or greater).

DASS-21

Participants in the survey had a mean stress score of 12.17 (SD = 7.26). Approximately 15% of the population had a moderate stress score, while 5% of the participants scores in the severe category, scoring 27 and above. Anxiety scores were much lower for this group, with a mean of 3.49 (SD = 4.03), with 5.5% and 2% of the group scoring in the moderate and severe ranges respectively. The mean depression subscale score for the group was 7.18 (SD = 7.57), with 12% of participants scoring within the moderate range, and approximately 5% scoring in the severe range.

As there were no clinically significant findings for ProQOL-5 burnout, two groups were investigated based on severity of symptoms they reported in the DASS-21, "high distress" (n=15) and "low distress" (n=74) cohorts. A combined DASS-21 score can be used to screen for general psychological distress (Antony et al., 1998; Crawford & Henry, 2003), however as each of the three subscales represents a separate but interrelated dimension of overall psychological distress, using either a combined DASS-21 score or individual subscales to investigate psychological distress are both valid uses of the DASS-21 scores (Henry & Crawford, 2005). The participants who symptoms of depression, anxiety and/or stress in the 'severe' and 'extremely severe' range on individual subscales of the DASS-21 formed the "high distress" cohort, while participants who reported 'normal' range scores across all three subscales formed the "low distress" cohort. An attempt was made to create a cohort group to investigate ProQOL-5 burnout symptoms, however no individuals who responded to the survey met the 75th percentile cut-off threshold conventionally used to define burnout in the ProQOL-5 (Stamm, 2010).

Qualitative analysis

A high degree of commonality was seen within the participants' self-reported responses, with few contradictions in the explanations or experiences of burnout within the cohort. Three overarching themes emerged from the data from the initial analysis: feedback and social aspects, self-care and personal factors, and structural/environmental factors that impacted the job of psychologists.

Feedback and social aspects of burnout

The feedback and social aspects theme illustrated a lack of social connection and supports as a widely suggested factor impacting the experience of burnout. Participants described situations where collegial support was hindered due to a myriad of factors: poor team dynamics, "toxic" workplaces, and social pressure. Some participants described workplace situations where they felt the need to appear that they had a high ability to cope with stressful situations, due to stigma existing around authentic discussion of workplace hardships. Others recognised how poor workplace relations had deeply affected them, but only retrospectively, due to the normalisation of unhealthy and toxic behaviours.

In some cases, psychologists reported being unable to form collegial bonds due to the sheer amount of work that was required for them to complete daily, or in the case of solo private practitioners, as there were in a situation with literally no other colleagues to interact with. Being a member of a team was typically seen in a positive light, however some problematic situations included experiences within a multi-disciplinary team. Being a member of such a team had the potential to lead to feelings of being undervalued, as their co-workers and managers had a lack of understanding of what a psychologist's role is and what their training entailed (especially in cases where a person was the only psychologist on a team).

Overall, psychologists placed strong value and emphasis on the importance of the relationship with their supervisors in preventing perceived burnout. The participants described situations where a poor relationship with supervisors (or situations where a psychologist receives feedback from a supervisor exclusively, without peer or collegial support), as factors which would impact burnout. They valued peer and collegial networks for their ability to debrief around both clients and systemic issues.

Table 1

Psychologists' Beliefs of What Feedback and Social Aspects Impact Burnout

Sub-theme	Illustrative quote
Clinical supervision	"All other psychologists in private practice are so full that I have struggled to find a supervisor. " "I am very aware that I need additional supervision when I break any of the [self-care rules] that I've made for myself."
Professional isolation	"That so few colleagues want to do this work creates a huge burden on my time and demand." "Do not isolate, find safe people to talk to authentically about burnout and formulate coping."
Team dynamics and workplace	"I didn't realise how bad it was until I left. It was an environment where staff cry a lot at work so I assumed this was normal."
Social pressure	"Despite the expressed invitations to be transparent, there still exists an unspoken culture (to my mind) which requires us to do more, be more, and be good at it immediately. "

Personal life factors impacting burnout

The second major theme evident from the responses was the impact of personal life factors upon a psychologist, or a lack of appropriate self-care. Relative to question two, psychologists were much more open to criticising others for poor habits, a lack of training or self-insight, a lack of a desire to see a psychologist and process their own trauma, or personality traits such as inflexibility as explanations for why colleagues may experience burnout, however these were rarely discussed self-reflexively. Many people believed experiences outside of work, such as personal life stress or grief, were major influences on the development of burnout. A lack of self-care techniques such as

exercise, diet and good sleep hygiene were identified as factors among psychologists, however the relationship between self-care and burnout was not straight forward or consistent for all responders. Some noticed that they tended to rely on self-care techniques more-so in times when they felt that they were experiencing burnout, while others felt that if they were experiencing burnout, the typical self-care techniques that they employ cease to be as effective. A highly detrimental situation was also identified by participants: increased burnout symptoms could lead to a person sacrificing self-care techniques or a work-life separation, which could fuel a vicious cycle of increasing burnout. Some participants felt that discussions of psychological distress and self-care needed to become more focal to psychology training programmes, as they believe that the training they had received had not prepared them for how much proper self-care impacted their wellbeing in the workplace.

Regarding self-care techniques, psychologists most often discussed the positive effects of exercise, sleep hygiene, relaxation, family and social connections, living with pets and a connection to nature. Some of the activities which psychologists identified as the most effective for them were activities which incorporated multiple aspects of self-care, such as swimming (which one responder praised as it incorporated both exercise and mindfulness techniques due to needing to practice breathing), yoga and gardening. Separation from work was considered a strong theme for choosing self-care techniques, such as holidays in distant locations, hobbies and interests outside of psychology, and breaks from working in the industry. Many psychologists described using psychologically-informed techniques on their own lives that people in other fields may not be as familiar with, such as incorporating ACT, CBT, self-compassion, behavioural activation and reframing techniques

Table 2

Psychologists' Beliefs of What Personal Factors Impact Burnout

Sub-theme	Illustrative Quote

Personal factors	"Perfectionism, unrelenting standards, tendency to be over-responsible." "Training programmes…not emphasising the importance of self-care, imposter syndrome and pressure as a psychologist to show you have it all together. "
Self-care	"All this contributes to burnout on top of exhausting people trapping them in a cycle where they cannot easily proactively respond to their burnout by engaging in the factors we know help with burnout (e.g. organisational commitment, social complexity, caring for physical health and self care)." "It's a full time job! Sleep, meditate, swimming in cold water, eat well, quiet weekends. I find that since covid I need much quieter weekends to recover from my work and am more prone to isolating myself."

Workplace, structural and environmental factors

Workplace, structural and environmental factors were some of the factors most emphasised by psychologists as leading to burnout, with many participants voicing frustrations and stating that the "system is broken". High caseloads and overall caseload management was emphasised as a crucial factor: many felt that there were too many clients who needed to be seen, too little time during their day to complete administrative tasks, and cases often had a higher severity and risk than they believed safe. Many believed that clients were waiting too long to seek help or be seen by a mental health professional (one participant described how their workplace felt it was necessary to change their definition of severity, in order to prioritise their long waiting-lists). A high number of clients seen per day typically affected participants by reducing their ability to recover between patients (i.e. to time to rest or to complete administrative tasks), and they noticed self-reported compassion fatigue: if a high number of clients were seen per day, this could cause them to stop

caring or empathising as deeply with clients. Some described feelings of overwhelm and mental anguish when needing to refuse patients or place patients on waiting lists; feelings of guilt over having no capacity to meet the needs of the population, and the lack of systemic resources for their clients (e.g. nowhere possible to refer clients to due to waitlists). In addition to stress during assigned work hours, psychologists recognised a break-down between the boundaries and distinction of work and home as a major contributing factor.

Psychologists believed that feelings of powerlessness in the workplace increased experiences of burnout: many noted an inability to change the health system, an inflexibility with management and inability to change their workplaces. Some psychologists noted that these feelings were heightened due to psychologists' roles within organisations: positions of high responsibility but low power to enact change. Many non-private practitioners noted a mismatch between the organisation's values or metrics and their own, such as focusing on efficiency, number of patients seen and billing over safe practice, or a too strong focus on the medical model over what psychology research has shown to be the most effective practices. Many psychologists believed that management preferred other professions that were cheaper to finance than psychologists (such as occupational therapists and social workers). Management themselves were also seen as problematic, with poor relationships with managers, bullying behaviour and micromanagement factors major concerns for psychologists.

Many participants reported problems specifically in DHB settings, and some described the benefits they experienced by moving to private practice or another setting. Exercising agency and making decisions about their work was often one of aspects participants felt improved their wellbeing: creating clear boundaries, reducing the workload or working part-time, and balancing a variety of complex and straight-forward clients throughout their working days.

Table 3

Psychologists' Beliefs of What Workplace, structural and environmental factors Impact Burnout

Sub-theme	Illustrative Quote
Autonomy	”High expectations, high degree of responsibility but little power to make decisions.”
Work/life balance	“…having to work evenings and weekends to keep up with case notes, reports and emails, to the extent that I don't really have an outside life to balance it all out.” “I have a clear separation of work and home; use my travelling home time to process the events of the day; try not to work outside of my paid work hours (or take time in lieu if I have had to alter my work hours); have hobbies and interests not associated with work.”
Caseload, admin and case acuity	“The backlog of demand – the endless stream of people needing help – the longer the wait the more complex and stressed the situation by the time they are seen. Can feel like trying to climb uphill in the face of an avalanche.” “High caseloads...not enough time to do paperwork and particularly planning for sessions. Needing to be a therapist, case manager and an administrator.”
Working outside of scope, psychology devalued by management	“[lacking a] sense of support from the team to practice as a psychologist rather than as a case manager – often not supported to work in a way consistent with psychology.” “Lack of understanding of the difference between a psychologist and other disciplines, such as occupational therapy, social work and nursing.” “Organisation regarding psychologists as expensive and wanting to replace psychology positions with cheaper professionals to employ, despite waiting lists for psychology”

Underpaid and undervalued	“HR and tiger corporate jobs get paid more and get more respect than a clin psych, as everyone seems to think they can do what a psych does.”
Organisational value conflict	“In my private practice I can set limits that work for me, be guided purely by best practice, my code of ethics and the needs/preferences of my clients and their families rather than bureaucratic systems designed by administrative types, psychiatrists and allied professionals who do not know what psychologists do and need or what service users need.“
Management issues	“Good workers are not valued, and problematic workers are not addressed or behaviour is reinforced. No clear structure or processes, lack of adherence to Te Tiriti especially for Māori clinicians”
Administration	“Feeling like tasks are never-ending and you're not ever finished.” “I have a PA. Without her I would have burned out a long time ago! She does all my invoicing and appointment scheduling. She says "no" in my behalf (and is very kind about it). She protects me from being sucked in by someone's story or their complaint that there are no available therapists.”

Additional factors

Additional themes were evident exclusively when psychologists were discussing their own personal anti-burnout techniques. Some people utilised professional development, future goals or reconceptualising negative aspects of their job as skills to be improved (e.g. improving your ability to set boundaries), while others found importance in psychology itself: an innate interest in human nature was a protective factor.

Many participants identified training programmes as being incongruent to real-life experience of being a psychologist, or not fostering the skills that are needed. Psychologists

identified the emphasis on competition, lack of self-care or discussion of imposter syndrome as factors that needed to be addressed, while feeling that programmes did not give trainee psychologists enough practical training programme experience, or enough familiarity with psychometrics.

Thematic differences were seen when comparing the responses to the two prompting questions. While discussing protective factors against burnout, psychologists tended to focus on self-care, however when discussing burnout on a systemic level, a lack of self-care was not typically discussed. Similarly, while a systems-based view encouraged discussions of operational changes that needed to be ratified, or a discussion of personal life factors, psychologists were much less likely to identify these in their personal relationship with mitigating burnout symptoms (and conversely, lack of self-care was only rarely discussed by participants when discussing systemic burnout factors). Performative self-care was identified as a potentially negative factor: the idea that a psychologist needed to appear to be a high self-awareness, high-functioning person who accepts themselves, as a model for clients to understand what good self-care looks like, could be potentially draining.

Client progress factors were also identified across the questions. Many people identified the lack of a sense of progress or closure in clients' stories as contributing to a sense of therapist inadequacy, while some psychologists recognised this and took steps to counteract these negative feelings, such as by having an innate trust that clients were progressing, having low initial expectations of clients (and then being surprised), or thinking positively about every situation (one participant described this as considering when clients want to come back as evidence that they are benefiting from the process, and when they want to stop coming as evidence that they have grown).

Mixed methods analysis

When suggesting potential factors that influence burnout in psychologists in general, most factors were identified consistently across both groups. The high distress group tended to identify complex and/or combatant patients as a burnout factor, while the low stress group tended to

identify management and workplace factors, or problems involving a work/life balance or boundaries between work and home.

The low distress group tended to identify vicarious trauma, over-identifying with clients, a lack of recovery time between patients, and an imbalance between the amount of administrative tasks and the number of clients sessions per day, while the high distress cohort tended not to identify these aspects. The low distress cohort also identified several aspects that they believed caused other psychologists' experiences of burnout which the high distress cohort did not identify: impostor syndrome, insecurity, personality factors, and unrealistic self-standards.

In terms of the techniques individuals used to counter burnout, the low distress group tended to discuss clinical supervision, collegial support and peer supervision, while the high distress group did not. The low distress cohort tended to mention work-life balance, especially techniques used to crate physical and mental barriers between the workplace and home, and decisions to work part-time. The high distress cohort tended to discuss the use of holidays and annual leave more frequently than the low distress cohort.

CHAPTER 4: DISCUSSION

Vicious cycles impacting professional quality of life and perceived burnout

The insights offered by practicing psychologists in this study provide valuable suggestions for the profession and the mental health workforce more broadly. The participants' descriptions depict a workforce that appears to face similar stressors as have been found in overseas studies, where high job demands, lack of agency in the workplace and poor professional community all were associated with higher risk of experiencing burnout (Simpson et al., 2019; Paris & Hoge, 2010; Rupert & Morgan, 2005; Yang & Hayes, 2020).

Several vicious cycles were evident from the self-reported qualitative data: situations where small negative changes could lead to catastrophic consequences. Higher demand led to less time

where psychologists could develop collegial bonds and receive feedback, which increased the likelihood of experiencing burnout symptoms. Higher patient severity led to longer hours needed to be spent with these clients, impacting the waiting list for their services, and in turn increasing the waiting time and severity of clients further down the list. Staff turnover was also a major vicious cycle identified by the participants: staff felt overworked, would experience burnout and leave their positions, meaning remaining staff at the service were now busier and significantly more likely to burn out. In DHB settings, a cycle was identified by one participant where senior staff consistently left the DHB, meaning there were few opportunities for mentoring and guidance, and that the most senior of the junior staff members were assigned cases outside their abilities, begin to feel overwhelmed, and leave. Some organisational settings tasked psychologists with working only the most complex cases, leaving no time for balancing work and a high level of stress.

It is interesting to note how many negative factors reported by psychologists can be traced to high caseloads and low numbers of available staff. Significant benefits to the quality of life of psychologists may be possible through targeting specific problems that were identified as root causes of vicious cycles. The most central of these aspects, as suggested by the data, is an improvement to staffing numbers (i.e. increasing the number of psychologists being trained, number of staff being retained overtime), which was linked in the data to patient severity, work-life balance, the forming of collegial bonds, professional isolation and mental distress over the need to refuse patients. Addressing this specifically, as opposed to focusing on an improvement of less central factors such as managerial styles, improving psychologist self-care and tracking client progress, would potentially see wide-spanning improvements to psychologists' professional quality of life.

Burnout symptoms

Burnout symptoms measured by the ProQOL-5 were noticeably lower than in a previous study of New Zealand psychologists (Temitope, 2014), and much lower than in similar samples of New Zealand doctors and counsellors (Huggard & Dixon, 2011; Temitope, 2014). Compared to the

previous study of New Zealand psychologists (McCormick, 2014), the current sample exhibited lower ProQOL-5 scores across both the compassion satisfaction and compassion fatigue subscales. Not only did this result contradict previous findings, this also contradicted the qualitative data received from the participants. The individuals who reported more intense feelings of burnout in their self-reports did not necessarily correspond to those with the highest ProQOL-5 burnout scores or DASS-21 scores. The participant's ProQOL-5 scores indicated that a large subsection of the survey were at-risk for developing burnout, even if they were not experiencing burnout symptoms at the moment when they completed the survey.

A self-selection sampling issue may account for low rates of reported distress, however as previous surveys of healthcare professionals in New Zealand similarly recruited volunteers through social media communities and professional body correspondence, this is unlikely. It is also unlikely a fault of the tool itself, as ProQOL-5 has been validated across a range of contexts, including previous studies involving New Zealand psychologists.

A possible explanation for these findings is that this is evidence of posttraumatic growth and increased resilience in the immediate aftermath of the initial 2020 COVID-19 lockdowns. Posttraumatic growth has been documented as having a positive impact on the professional quality of life of healthcare professionals after experiencing vicarious trauma from clients or from major disasters (Hyatt-Burkhart, 2014; Tominaga et al., 2014). While this effect has not been systemically investigated due to the recency of the COVID-19 pandemic, some evidence has emerged that healthcare professionals' overall ProQOL scores had lowered since the initial wave of the COVID-19 pandemic, due to either lower compassion fatigue, higher compassion satisfaction, or a combination of both, in locations such as Iran, Italy and the US (Azizkhani et al., 2022; Dwyer et al., 2021; Franza et al., 2020), however one study reported no difference for healthcare workers' ProQOL scores during the COVID-19 pandemic compared to statistical averages (Inocian et al., 2021), and the

COVID-19 pandemic has been identified in the literature as being likely to have negatively impacted the wellbeing of Aotearoa New Zealand (ASMS, 2021).

Another possible explanation for the lack of high ProQOL-5 burnout scores is nonresponse bias and survivorship bias: people experiencing the strongest burnout symptoms likely had additional barriers stopping them from engaging with surveys (such as having too little time to complete the survey, or any members of the population who changed careers due to burnout experience would not have been captured by the survey (Dunwoodie & Auret, 2007; Peisah et al., 2009). Survivorship bias has been noted in longitudinal surveys of population-level mental health (Czeisler et al., 2021) and participants who began the survey but did not complete all measures (or for qualitative questions, gave no answer or very brief replies) may represent a systematically different type of responder compared to those who completed all fields (Walters, 2021). That the high distress cohort tended to answer the qualitative questions with fewer words and less detail than the low distress cohort may be evidence for this effect, however there is no evidence for this potential factor being stronger or weaker than in previous healthcare and mental health worker surveys which did not show low burnout scores.

Irrespective of the lack of severe burnout scores, New Zealand psychologists reported mid-range burnout symptoms and some reported high rates of psychological distress. They described a system where overwork, devaluation, a lack of resources and few chances for collegiate connection and professional development created a suboptimal environment, which they saw as detrimental to their professional quality of life and believed caused burnout among themselves and their colleagues. Many participants, while not meeting the 75th percentile scores recommended by the measure's authors as an indication of burnout, showed moderate scores indicating the participants were at-risk of burnout (burnout being a phenomenon with a gradual onset). These self-reports should not be ignored. The open survey questions are consistent with findings of a recent study of New Zealand Psychiatrists' wellbeing, which described psychiatrists as overwhelmingly feeling under-resourced,

with a lack of time and support (ASMS, 2021). Psychiatrists similarly had low trust in management, who they felt had unrealistic expectations and a poor understanding of care (ASMS, 2021).

Limitations

A range of contextual factors may have influenced the participants' self-reports, including the priming effects of the questions asked in a mental health survey, with participants having completed psychometric measures discussing their mental health immediately before completing the self-reported sections. Context of question delivery and survey design are known to influence survey answers (Mieczkowski et al., 2020; Teunissen et al., 2009), meaning this effect should be actively considered when interpreting responses. Within the question items, the term "burnout" was never given a formal definition, meaning participants relied on their intuitive and/or prior understanding of the construct.

As with all voluntary self-report surveys, systemic biases and errors such as nonresponse bias are issues that can confound data and interpretation (Hemsworth et al., 2018; Walters, 2021). The survey had a high response rate in terms of the total population of practicing psychologists in New Zealand, however the demographic make-up did not match the total population (especially in terms of a lack of Māori/Pasifika, male and gender-diverse participants). Burnout and low professional quality of life has been known to affect Māori working within mental health occupations (Hemopo, 2004; Levy, 2002), which may explain some of the lack of quantitative findings. Experiences unique or more common among Māori/Pasifika, male and gender-diverse psychologists that impact their professional quality of life and understanding of burnout may have been absent or underrepresented among the psychologist self-reports, meaning that the analysis should not be understood as comprehensively representing all experiences of Aotearoa New Zealand psychologists. Conversely, as burnout is more strongly seen among women psychologists globally (McCormack et al., 2018), that women were overrepresented in the same meant there was a greater risk of burnout symptoms being overrepresented.

The survey design itself may have influenced how responses by survey participants. As the open-ended questions were brief survey items, they may have created blindspots or limitations for how rich the data could have become, compared to expended semi-structured interviews where participants could elaborate on their thoughts, and where an interviewer could question aspects that participants may have not considered in the brief moments when completing the survey (i.e. what participants decided to write was not an exhaustive list of their experiences). The qualitative questions were asked specifically within the context of personal mental health, as participants had immediately completed measures of resilience, client collaboration and personal accomplishment, meaning participants may have been primed to consider these factors when completing the open survey questions. Despite these limitations, very similar themes emerged in comparable studies which used extended interviews (Alfrey, 2014; Hammond et al., 2018; Turnbull & Rhodes, 2021). As each individual participant was asked to consider multiple aspects of what they thought of professional burnout, this allowed for 260 unique impressions among the survey participants, hopefully removing many blindspots for the participants who completed the open-ended survey.

As with all qualitative research, a major limitation is that the research authors and people who process qualitative data influence the results through conscious and unconscious personal biases and opinions (Starks & Trinidad, 2007). The primary researcher, being a postgraduate psychology student, naturally has biases as they are not imbedded in the subject to the same degree as the participants are; despite having similar experiences and knowledge of what professional burnout entails, as the researcher was not a registered psychologist working within the system, there is potential for aspects of the self-reported experiences of the participants to have been misinterpreted. Similarly, the Hawthorne Effect – the knowledge that participants know that their responses will be studied (Wickström & Bendix, 2000), is a known aspect that may have influenced both qualitative and quantitative aspects of the study, by research participants altering their responses to appear more professional or to act more congruent with the study's scope. An attempt to mitigate this effect was made by having the survey be completed anonymously.

Conclusion

Psychologists in Aotearoa New Zealand report difficult working environments due to high client numbers, high severity of clients and few resources, in addition to a range of systemic and managerial problems. These issues are similar to those reported in other health professional fields in the country, as well as psychologists globally. A high risk of burnout, associated with poor professional and client outcomes, has been identified across mental health professions in Aotearoa New Zealand, and steps need to be taken to mitigate this. Psychologists in Aotearoa New Zealand currently employ a range of self-care techniques to mitigate burnout symptoms, and place high value in peer and supervision networks. Interventions specifically targeting the increase in psychologist numbers may likely be a method to greatly increase the professional quality of life for psychologists, as the understaffing of psychologists was a central theme involved in many issues psychologists identified as impacting their professional lives.

Future research should investigate the relatively low ProQOL-5 burnout scores seen in this sample, to understand more of the context around this finding, if burnout scores are increasing, and adding understanding for what specific strategies can best support the workforce before they experience burnout, to ensure positive outcomes for clients, and to create a sustainable workforce of professionals.

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