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**“A systematic review of relationships between burnout and consciously-initiated
autonomous self-care interventions in psychotherapists”**

and

**“Is psychotherapist self-care self-determined? The roles of autonomous motivation,
work demands, professional stigma, high standards, and self-sacrifice.”**

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Dedication

I wish to dedicate this work, and all associated efforts and hours, in thanks to my family and friends, who continually prove they merit no such distinction. Everyone, I thank you in perpetuity for the kindness, laughter and support you have always freely offered, and which it is my deepest privilege to share.

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Thesis Abstract

Psychological interventions and the psychotherapists who provide them are crucial to meeting existing and escalating global mental health demand. Unfortunately, psychotherapists are at high risk of experiencing occupational distress, particularly burnout. Detrimental impacts affect both psychotherapists themselves, and their ability to effectively provide psychological interventions. Remediating psychotherapists' occupational distress and burnout at work is therefore a priority. Unfortunately, research of this kind in psychotherapists is limited, particularly in terms of effective, individually-targeted interventions. This literature gap conflicts notably with widely-shared and common assertions that psychotherapists can prevent burnout themselves via self-care. While self-care is indeed an ethical and professional imperative for psychotherapists, demonstrates emerging wellbeing benefits, and is therefore worthy of promotion, evidence regarding its impacts on burnout requires further investigation.

The first chapter of this thesis presents the results of a systematic review evaluating extant evidence of relationships between consciously initiated, autonomous self-care interventions and burnout in psychotherapists. A systematic literature search identified 18 published and unpublished studies which were included in a narrative synthesis of findings. Most studies were of questionable quality, and all used cross-sectional designs, limiting overall inference. Results however found the greatest support for a negative relationship between burnout and self-care interventions promoting work-life balance. More broadly, findings highlighted the possible importance and utility of more restorative and preventative approaches for reducing burnout, particularly those involving self-regulation and self-awareness to promote recovery from work and boundaries between work and home life. Practical clinical implications were discussed and recommendations for future research were made based on review findings and noted literature limitations.

The second chapter of this thesis reports the results of a cross-sectional empirical study investigating factors identified from the literature which may inhibit or promote psychotherapists' self-care. Expected self-care barriers included work demands (both objective and subjective), professional stigma, and psychotherapists' internalised tendencies towards high performance standards and self-sacrifice. The role of autonomous motivation towards self-care, conceptualised in line with Self-Determination Theory, was also considered as a possible self-care facilitator. Findings of correlational and hierarchical regression analyses were mixed, highlighting that distinct variables related differently to distinct self-care domains. Specifically, self-care in broadly personal domains was most strongly negatively related to perceived workload demands, whereas professional self-care was mostly negatively related to perceived workplace stigma. Autonomous motivation toward self-care appeared to positively relate to self-care, though was seemingly most impactful when perceived workplace demands and stigma were lower.

Both chapters collectively highlighted the importance of self-care specifically for maintaining psychotherapists' daily balance, as it was both the most clearly negatively related to burnout, but also the form of self-care most likely detrimentally impacted by identified barriers. This thesis further extended findings in the general occupational and health psychology literatures to the issues of psychotherapist wellbeing and self-care, and highlighted factors worthy of practical consideration and future research prioritisation.

Lay Summary

For a long time, and especially since the COVID-19 pandemic, there has been more people needing mental health support than there are people providing it. An important way to support mental health is by providing talking therapies. The group of staff who do this are called psychotherapists. Unfortunately, the type of work psychotherapists do can be very stressful, and they can become “burned out”. This makes it much harder for them to help others. Keeping psychotherapists well increases the chance everyone can get the mental health support they need.

One of the ways psychotherapists can stay well is by looking after themselves. This is called self-care, and psychotherapists’ professional guidelines state they are expected to do this routinely to make sure they can do their job as well as possible. While it is important and helpful that psychotherapists do self-care, it is not so clear that it actually stops them burning out.

The first part of this thesis looked at existing evidence to see if self-care and burnout were related. It was found that some types of self-care did relate to burnout but the quality of evidence was not very high. The strongest evidence found suggested that when self-care aimed at keeping a good work-life balance went up, burnout went down, and vice versa. Also, overall, types of self-care aimed at “getting ahead” of stress and watching out for it seemed more well-supported by evidence than self-care used in response to stress.

The second part of this thesis looked at things that could help or hinder psychotherapists’ self-care. Possible barriers to self-care included psychotherapists having lots of work demands, pushing themselves too hard to do their job well, putting other people’s needs first, and finding it scary admitting to their co-workers that they need to look after their own mental health sometimes, because this is what they all do for a living. One thing thought to maybe help self-care was psychotherapists feeling in charge of and invested in self-care (“autonomously-motivated”), instead of only self-caring because they know they should. This study found that different barriers affect different types of self-care. Personal self-care, like making sure to take breaks at work, not working too hard when not needed, and using time off well, went down most when psychotherapists felt like they were being asked to do too much too quickly or do too many things at once. Professional self-care, like speaking to co-workers for help or getting more skills via training, went down most when psychotherapists felt unsafe sharing their difficulties with colleagues. Feeling autonomously-motivated to self-care was helpful, but mostly when these other problems weren’t there.

Overall, this thesis showed it is particularly important for psychotherapists to strike a good work-life balance, because this is likely the most helpful thing to do to help burnout, but also because it is the type of self-care most strongly and negatively impacted by psychotherapists feeling overworked, which is likely in their busy jobs.

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Chapter 1. Systematic Review

Title Page: Systematic Review

A systematic review of relationships between burnout and consciously-initiated autonomous self-care interventions in psychotherapists.

[RUNNING TITLE – BURNOUT AND PSYCHOTHERAPIST SELF-CARE]

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[NOTE: Both this title page and the following chapter have been prepared in accordance with author submission guidance for The Journal of Clinical Psychology. Adjustments were made regarding placement of tables/figures and word count, with respect to thesis submission requirements. Author submission guidelines are included in full in **Appendix A**]

Systematic Review Abstract.

Objectives: Psychological interventions and the psychotherapists who provide them are crucial to meeting existing and escalating global mental health demand. Unfortunately, psychotherapists are at high risk of experiencing occupational distress, particularly burnout. Detrimental impacts affect both psychotherapists themselves, and their ability to effectively provide psychological interventions. Remediating psychotherapists' burnout is therefore a priority. Unfortunately, research of this kind in psychotherapists is limited, particularly in terms of identifying effective, individually-targeted interventions. This literature gap conflicts notably with assertions that psychotherapists can prevent burnout themselves via self-care. The present study aimed to review existing evidence for relationships between psychotherapists' burnout and self-care, defined as consciously-initiated autonomous self-directed interventions.

Methods: Following PRISMA guidelines, this review identified studies by systematically searching EMBASE, MEDLINE, PsychINFO, CINAHL, ASSIA, Scopus, ProQuest Dissertations and Theses, and Cochrane Library databases for published and unpublished sources. Searches identified 837 records, 76 of which underwent full-text review. A final selection of 18 studies meeting inclusion criteria were subjected to a narrative synthesis.

Results: Most studies identified were of questionable quality and all used cross-sectional designs, limiting causal inference. Considering study quality, the best-supported findings were that self-care facilitating work-life balance, was most strongly negatively related to burnout. Overall, more preventative approaches based on self-regulation and self-awareness, and facilitating recovery from work, demonstrated the greatest support.

Conclusion: Results broadly suggest the potential importance of psychotherapists maintaining good work-life balance and making good use of recreation time, in preventing or remediating burnout. This also suggests that the concepts of psychological disconnection and recovery from work, as evidenced in the general occupational literature, is likely an area of particular importance in preventing psychotherapist burnout, worthy of future research.

Keywords: Psychotherapists, Burnout, Self-Care, Recovery from Work, Work-Life Balance.

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Introduction

Evidence-based psychological interventions are both effective and integral to supporting population mental health (Patel et al., 2016, 2018). They can be more simply collectively described as “psychotherapy”, given extant definitions and guidance converge in agreement that: (1) Such interventions either represent or employ scientifically-validated psychological principles, procedures and methods; (2) The shared aim of the intervention is to promote mental wellbeing, likely via the modification of individuals’ cognitions and behaviours; (3) Intervention primarily involves collaborative interpersonal interaction between an individual seeking assistance for a particular mental disturbance or disorder, and a professional with specific relevant training in delivering psychotherapy (European Association for Psychotherapy, 2022; NICE, 2009, 2011a, 2011b, 2019; NHS Education for Scotland, 2014; NHS Health Education England, 2022a; VandenBos, 2015; Wampold & Imel, 2015). Psychotherapy’s importance is highlighted by current UK clinical guidance. Considering all stages of the stepped-care responses outlined (NICE, 2009, 2011a, 2011b, 2019), psychotherapies constitute the most frequently recommended intervention type for the most prevalent mental health difficulties observed prior to and following the COVID-19 pandemic (anxiety and depression) (Vos et al., 2020; WHO, 2022).

Demand for psychotherapy has however long exceeded availability and continues to do so, both in the UK (Bird, 2006; Public Health Scotland, 2022; Rimmer, 2018; We Need to Talk Coalition, 2013, 2017) and globally (Harvey & Gumport, 2015; Kazdin, 2017; Moitra et al., 2022). Proposals to increase availability of psychological therapies include increasing the number of psychotherapists and those in training; increasing delivery by non-psychotherapists via task sharing or program-led interventions; or increased technological innovations (e.g. telemedicine) (Fairburn & Patel, 2014; Harvey & Gumport, 2015; Kazdin, 2017; Patel, 2022). These developments however likely require significant co-ordination, effort and funding commitment at national, governmental and organisational levels (Harvey & Gumport, 2015; Patel, 2022). This cannot be presumed at present due to increased mental health service demand (Akay, 2022; Santomauro et al., 2021) and a negative global economic outlook (International Monetary Fund, 2022b, 2022a). Further, such developments still require sufficient available psychotherapists to train and supervise any expanding workforce (Fairburn & Patel, 2014; Kazdin, 2017; Patel, 2022), or to most effectively facilitate wider systemic changes (Harvey & Gumport, 2015). Consequently, there is an immediate and ongoing need to protect and maintain the existing psychotherapist workforce.

While this workforce arguably includes several professions (NHS Health Education England, 2022a; VandenBos, 2015), not all are equally likely to deliver psychotherapy. Psychiatrists vary significantly in their levels of relevant training and worktime spent providing psychotherapy relative to pharmaceutical interventions (Gabbard, 2007; Hadjipavlou et al., 2015; Harrison et al., 2011; Holmes et al., 2007; Mojtabai & Olfson, 2008; NHS Health Education England, 2022b; U.S. Bureau of Labor Statistics, 2022a). Similarly, with some exceptions (e.g. “clinical social workers” in the United States), psychotherapy is not a universally defining duty of mental health nurses and social workers

(Hurley et al., 2022; IFSW, 2022; U.S. Bureau of Labor Statistics, 2022c). By comparison, and in response to increased demand, several roles have recently been created within United Kingdom health services which are expressly focused on the delivery of psychological therapies (Department of Health, 2008; The Scottish Government, 2010; Wakefield et al., 2021). These include Clinical Associates in Applied Psychology (The Scottish Government, 2010), Psychological Wellbeing Practitioners, and High Intensity Therapists (Psychological Professions Network, 2018, 2022). Similarly, delivering or indirectly supporting the delivery of psychotherapy (e.g. by supervising or training others) commonly forms the most substantive proportion of professional duties for Clinical Psychologists and Counsellors (NHS Health Education England, 2022d; U.S. Bureau of Labor Statistics, 2022b). Distinguishing between those who predominantly deliver psychotherapy and those who do not is important, as differences in duties and responsibilities, even within the shared professional sphere of mental health, likely result in significant variations in how distinct professionals can best be supported, due to varying experiences of occupational stress/wellbeing (Y. Lee et al., 2019; O'Connor et al., 2018; Paris & Hoge, 2010). This is highlighted when considering the experiences of the staff described above who are most consistently and frequently tasked with delivering psychotherapy.

Staff whose roles focus predominantly on delivering psychotherapy experience the same personal, occupational and situational stressors (e.g. health, finances) as the general population (Nissen-Lie et al., 2021). They also experience several role stressors likely shared with other health professionals, including those relating to clinical responsibility, uncertainty regarding patient outcomes, actual or perceived time management and workload pressures, and exposure to intense emotions, trauma and individuals in crisis (E. Baker, 2003b; Hannigan et al., 2004; Kramen-Kahn & Hansen, 1998; M. Lee et al., 2020; McCormack et al., 2018; Norcross & VandenBos, 2018a; O'Connor, 2001; Westwood et al., 2017). However, additional stressors arise specifically due to delivering psychotherapy (E. Baker, 2003b; O'Connor, 2001). Those predominantly spending their day delivering psychotherapy must spend a significant proportion of work time in physical isolation engaging in direct and sustained therapeutic contact (McMahon, 2018; Norcross & VandenBos, 2018a). This psychotherapeutic work is time- and labour-intensive, complex, inexact, and largely progresses at a slow, incremental pace (E. Baker, 2003b; Sherman, 1996). Those professionals conducting psychotherapy most consistently are therefore most likely to be exposed to distressing, cognitively and emotionally taxing work for more sustained periods (E. Baker, 2003b; Simpson et al., 2019). Additionally, they are required to constantly monitor, evaluate, manage or even repress their own emotional responses and psychological sensitivities when delivering psychotherapy, in order to maximise therapeutic efficacy (E. Baker, 2003b; Norcross & VandenBos, 2018b; O'Connor, 2001). They also appear required to do so with high precision, as occupational distress in these practitioners has been associated with both too much (emotional-focused) and too little (emotion-avoidant) emotional involvement (Simionato & Simpson, 2018).

Collectively, experienced occupational distress for those professions most consistently tasked with providing psychotherapy appears distinct from those in related professions (J. Johnson et al., 2020). Given the above, and recognising their consequent likely importance in providing and expanding psychotherapies, the term “psychotherapist” hereafter refers only to those whose central role task is the delivery and support of psychotherapy (Brent & Kolko, 1998; Simionato & Simpson, 2018).

Unfortunately, psychotherapists are at high risk of occupational distress and consequent professional impairment, a matter requiring consideration by researchers, educators, policymakers and professional organisations, to ensure optimal provision of psychotherapies is maintained (Farber & Heifetz, 1981; Guy et al., 1989; J. Lee et al., 2011; Posluns & Gall, 2019; Smith & Moss, 2009; Summers et al., 2021).

The Scale and Impacts of Psychotherapists’ Occupational Distress

Psychotherapists’ occupational distress has been most frequently evidenced and explored in terms of burnout (J. Lee et al., 2011; M. Lee et al., 2020; Lim et al., 2010; McCormack et al., 2018; Rupert et al., 2015; Yang & Hayes, 2020). Corresponding with current ICD-11 classification and the wider literature (Guseva Canu et al., 2021; WHO, 2019), burnout is most frequently defined in psychotherapists using Maslach and Jackson’s (1997) second revision of their original definition: as a syndrome arising via unmanaged chronic workplace stress, characterised by emotional exhaustion, depersonalisation and reduced personal accomplishment (M. Lee et al., 2020; McCormack et al., 2018). Despite previous prevalence estimates ranging widely (between 2% to 40%), a recent systematic review found 54.5% of trainee and qualified psychotherapists ($N=8808$) experienced moderate to high burnout (Simionato & Simpson, 2018). This is significantly concerning given known impacts of burnout in psychotherapists.

Burnout has demonstrated negative relationships with job satisfaction, and positive relationships with intention to quit or leave the profession (J. Lee et al., 2011; Raquepaw & Miller, 1989). Further, burnout is noted as a common feature of unintended professional misconduct, commonly implicated in detrimental impacts to patient well-being and therapeutic progress (Simionato et al., 2019). Examples include disrespecting or disengaging from patients or their role, making increased mistakes, and a general loss of interest (Pope & Vasquez, 2016; Rupert et al., 2015). These observations align with empirical findings in which burnout was negatively associated with treatment outcomes in UK psychotherapists (Delgadillo et al., 2018), and was identified as the leading self-reported factor detrimentally impacting psychotherapeutic effectiveness by US clinical psychologists (Bearse et al., 2013). Further, psychotherapists experiencing therapeutic inefficacy due to burnout are likely to experience reduced professional satisfaction, exacerbating burnout symptoms and potentially creating a vicious cycle (Simionato et al., 2019; Zarzycka et al., 2021). Finally, as well as direct impacts, burnout has demonstrated emerging evidence as a precursor to other forms of more chronic distress, including depression (Tóth-Király et al., 2021), compassion fatigue (Cocker & Joss, 2016) and secondary traumatisation (Shoji et al., 2015).

Given the above, burnout represents a significant threat to psychotherapists' wellbeing, and hence the efficacy and availability of psychotherapy (E. Baker, 2003b; Barnett & Cooper, 2009; Simionato & Simpson, 2018). Identifying ways to prevent or remediate burnout in psychotherapists therefore remains a significant research priority.

Remediating Psychotherapist Burnout

Current Context, Theory and Findings

Literature reviews of both the wider workforce, and mental health staff more specifically, note that burnout can be prevented or remediated by interventions targeted at either an individual, their employing organisation, or some combination of both. Further, these interventions can encapsulate anything within a wide range of actions or strategies intended to promote mental wellbeing or reduce burnout (Dreison, Luther, et al., 2018; Leiter & Maslach, 2014; NICE, 2022a, 2022b, 2022c). To align with this wider literature, distinguish from the evidence-based psychotherapeutic interventions discussed previously, and for ongoing clarity, from this point on the term "intervention" shall be used more generically to collectively describe any purposeful or targeted actions or strategies, with respective targets and aims specified as required.

Research exploring interventions to prevent or remediate burnout in psychotherapists is unfortunately and notably lacking (Yang & Hayes, 2020). Studies have largely identified risk factors for burnout as potential intervention targets, though most do not indicate an underlying theoretical basis as to how interventions targeting these risk factors may influence burnout (McCormack et al., 2018; Rupert et al., 2015). Of those that do, the most frequently mentioned models include The Jobs Demands Resources Model (JD-R) (Demerouti et al., 2001) and the Conservation of Resources Model (COR) (Hobfoll & Freedy, 1993; McCormack et al., 2018; Rupert et al., 2015). Both models cite the importance of resources for preventing burnout (A. Bakker & de Vries, 2021; Hobfoll Stevan & Shirom, 2001). The COR model defines resources as anything valued (including states, objects or conditions) that individuals are either motivated to protect, or that help attain goals (Halbesleben et al., 2014). The JD-R model separates job and personal resources, described as any factors respectively supporting goal attainment, well-being and personal growth/development (A. Bakker & Demerouti, 2017; Demerouti et al., 2001), or self-related resiliency factors, especially self-beliefs regarding perceived control, ability and mastery in responding to challenges (A. Bakker & Demerouti, 2017; Hobfoll et al., 2003). Both models describe work demands as physical, social or organisational role aspects requiring sustained physical or mental effort, which contribute to burnout either by overwhelming (Demerouti et al., 2001) or depleting (Hobfoll & Freedy, 1993) existing resources.

Both models therefore align with theoretical developments increasingly espoused in the wider occupational literature, conceptualising burnout's development as arising due to a problematic imbalance or incongruence between individuals' resources and their specific work demands, implicating both require consideration (Leiter & Maslach, 2014; Maslach, 2017; Maslach & Leiter, 2017). This concept of a process, in which detrimental impacts of acute stressors accumulate and

become more chronic should transactional interactions between an individual's resources and their environment's demands not otherwise successfully interrupt escalation, is a universally-shared aspect of prominent empirically-supported models of occupational stress development (Dewe et al., 2012; Kelloway et al., 2008). It is further supported by longitudinal meta-analytic findings in the wider occupational literature (Ford et al., 2014; Guthrie et al., 2020; Sonnentag & Frese, 2012). Correspondingly, current clinical guidance acknowledges both individually- and organisationally-targeted interventions are required to optimally support general staff wellbeing (NICE, 2022c). However, recognising the workplace as a primary stressor source (Moss, 2020), organisational interventions are seen as foundational, and irreplaceable by individually-targeted interventions alone (NICE, 2022c).

Consistent with these theories and clinical recommendations, several job demands have been identified significantly and positively relating to psychotherapist burnout, offering a wide range of potential targets for organisational-level burnout interventions. These include hours worked, experiencing more admin than clinical work, perceived job stress or overload, time pressures, and a lack of workplace control/autonomy and support (J. Lee et al., 2011; M. Lee et al., 2020; Lim et al., 2010; McCormack et al., 2018; Rupert et al., 2015; Yang & Hayes, 2020). Unfortunately, the literature exploring psychotherapists' individual resources is far more limited (McCormack et al., 2018; Rupert et al., 2015; Simionato & Simpson, 2018). Also, most individual factors with the greatest empirical support, most frequently studied and implicated, are demographic variables not easily modified (e.g. younger age, gender) (Lim et al., 2010; McCormack et al., 2018; Simionato & Simpson, 2018). While helpful in identifying those at higher burnout risk, these findings are largely unhelpful in suggesting possible individually-targeted burnout interventions for psychotherapists.

It must be acknowledged that prior, significant and potentially detrimental biases exist in the burnout and mental health literature, focusing change at an individual rather than system level (Leiter & Maslach, 2014; Maslach, 2017; Morse et al., 2012; Moss, 2020). Nonetheless, the identification of individual resources that enable psychotherapists to reduce their risk of burnout, which could in turn inform the potential design of individually-targeted burnout interventions, appears to be a crucial research gap. This gap however stands in stark contrast to the weight of recommendations regarding psychotherapist self-care.

Self-Care Defined and its Possible Role in Remediating Burnout

It is emphasised within psychotherapists' professional and ethical standards that they must routinely self-care, monitor and proactively attend to their own experienced distress and impairment (APA, 2021; Canadian Psychological Association, 2017; European Association for Psychotherapy, 2018; HCPC, 2016). Given the significant potential detrimental impacts, a significant body of literature has further identified self-care as an ethical imperative for psychotherapists throughout training and their careers (Bamonti et al., 2014; Barnett et al., 2007; Bohall & Bautista, 2017; M. Collins & Cassill, 2021; Maranzan et al., 2018; Miller, 2021; Norcross & VandenBos, 2018b; Pope & Vasquez, 2016; E. Wise et al., 2012; E. Wise & Barnett, 2016). Further, routine individual self-

care is frequently promoted as a method for psychotherapists to proactively prevent burnout (E. Baker, 2003a; Bamonti et al., 2014; Barnett et al., 2007; Posluns & Gall, 2019; Rupert et al., 2015; Simionato et al., 2019). However, this assertion has received only tentative empirical support, with further research advocated (Rupert & Dorociak, 2019).

A lack of empirical findings regarding psychotherapist self-care may result from historic and ongoing definitional breadth and inconsistency (Jiang et al., 2020). The term “self-care” first referenced patients’ self-management of health/illness, with this meaning predominating since (Godfrey et al., 2011). Self-care however increasingly describes individually-enacted and self-directed interventions promoting wellbeing and professional functioning in psychotherapists and social workers (E. Baker, 2003a; Bressi & Vaden, 2017; Colman et al., 2016; Jiang et al., 2020; J. J. Lee & Miller, 2013; Rupert & Dorociak, 2019). This conceptualisation of self-care has developed largely atheoretically, having been defined exclusively via the qualitative experiences, insights and opinions of a limited number of practitioners (E. Baker, 2003a; Coster & Schwebel, 1997; Dlugos & Friedlander, 2001; Kramen-Kahn & Hansen, 1998; Norcross & VandenBos, 2018a; Rupert & Kent, 2007). Self-care has therefore variously been conceptualised as guiding aims of practice (Norcross & VandenBos, 2018a), self-regulatory and awareness processes (E. Baker, 2003a), but most frequently as specific self-directed cognitive or behavioural interventions (Barnett et al., 2007; Dorociak, Rupert, Bryant, et al., 2017; Norcross, 2000). Seeking to capture these interventions, empirical measures have been recently developed using qualified and trainee psychotherapists (Jiang et al., 2020). Drawing on prior empirical and theoretical literature, expert review and consultation, and related instruments and population surveys, authors collectively identified a wide range of diverse self-care interventions, broadly categorised into personal and professional domains (Dorociak, Rupert, Bryant, et al., 2017; J. J. Lee et al., 2020; Santana & Fouad, 2017).

Despite ongoing definitional challenges, three common components emerge in research concerning psychotherapists self-care: (1) It involves autonomous, purposeful effort and engagement on the part of psychotherapists; (2) The effort’s function is attaining/maintaining holistic wellbeing; (3) It encapsulates a breadth of cognitive and behavioural interventions, applied in multiple domains (Colman et al., 2016; Dorociak, Rupert, Bryant, et al., 2017; J. J. Lee et al., 2020; Santana & Fouad, 2017).

This definition of self-care overlaps partially with the previously-discussed concept of personal resources, the terms also having been used interchangeably referencing psychotherapists’ burnout (Rupert et al., 2015). Personal resources however, as defined within JD-R and COR models, go beyond the cognitive and behavioural interventions represented by self-care, also encapsulating personality traits and beliefs (e.g. self-efficacy, optimism)(A. Bakker & de Vries, 2021; Hobfoll et al., 2018). It is however unlikely individuals’ could purposefully mobilise or control personality traits in response to burnout (Lazarus, 2006) as they represent relatively enduring and temporally-stable characteristic patterns of cognition and behaviour, unlikely to change quickly or without significant effort (Damian et al., 2019; Harris et al., 2016). Similarly, beliefs and appraisals can both be acquired,

and influence cognition and behaviour, without individual awareness or intention (Dasgupta, 2013). These points are reflected in more recent JD-R model developments, which distinguish between more fixed and stable resources, and the self-regulatory cognitions and behaviours thought to maintain them (A. Bakker & de Vries, 2021; Wrzesniewski & Dutton, 2001). Considering the above, self-care as currently contextualised and operationalised in psychotherapists could only represent a subset of resources, namely cognitive or behavioural interventions able to be consciously and autonomously enacted to recover from, adjust to or cope with work stress (Demerouti, 2015).

On a similar theme of autonomy and control, definitional confusion appears to exist in the literature regarding other potential resources in psychotherapists. For example, while receiving clinical supervision is asserted as a form of self-care (Skovholt & Trotter-Mathison, 2016), the restorative role of supervision is not a universally or equally emphasised component (Kühne et al., 2019; Milne & Watkins Jr, 2014). Further, evidence exists that supervision can potentially involve power misuse, boundary violations, and fractured supervisory relationships (Watkins Jr, 2017). Any potential benefits are therefore contingent on satisfactory supervisory relationships not fully within psychotherapists' control (Kühne et al., 2019). Consequently, objective measures of availability regarding supervision or other social supports, despite being labelled as such (Posluns & Gall, 2019), cannot universally represent self-care. However, autonomous individual efforts to maintain or utilise valued support systems would (Colman et al., 2016; Dorociak, Rupert, Bryant, et al., 2017).

Even considering the above definitional restrictions, several routes remain, consistent with extant theory, by which self-care may support staff wellbeing (A. Bakker & Demerouti, 2017; Holmgreen et al., 2017; Mayerl et al., 2016). These include by: (1) increasing personal resources and/or reducing or altering workplace demands (A. Bakker & de Vries, 2021; Demerouti, 2015); (2) attaining or bolstering job resources (e.g. peer, co-worker support) (Demerouti et al., 2001; Dorociak, Rupert, Bryant, et al., 2017; Schaufeli & Bakker, 2004); (3) protecting or replenishing other valued resources, or supporting goal achievement regarding wellbeing and professional functioning (Halbesleben et al., 2014; Hobfoll, 2001); (4) strengthening individuals' perceived belief they can successfully respond to challenges (Hobfoll et al., 2003).

Literature Summary and Aims of This Systematic Review:

Considering literature reviewed, there is a significant lack of research exploring effective individual-level resources or interventions which could help prevent or remediate psychotherapists' burnout. By notable contrast, a significant body of literature and guidance asserts that individual psychotherapists' conscious, autonomous and routine enactment of self-care is crucial to preventing burnout and maintaining professional efficacy. Empirical study is further complicated by the breadth of interventions the term self-care could encapsulate (Rupert & Dorociak, 2019), self-care's many, wide-ranging extant definitions (Godfrey et al., 2011), and the term overlapping significantly with several related concepts (e.g. "coping") (Lazarus, 2006).

It has consequently been noted a systematic literature review examining psychotherapist self-care could advance understanding of potentially effective interventions most worthy of prioritisation by future research, or for swift implementation in practice (Morris, 2018; Posluns & Gall, 2019). Such a review would simultaneously address the aforementioned gap in research regarding individual resources that may influence psychotherapist burnout (McCormack et al., 2018).

Considering the above, the completion of a systematic review is proposed aiming to answer the following research questions:

1. What current evidence exists relating consciously initiated, autonomous self-care interventions to burnout in psychotherapists?
2. Which if any interventions appear potentially effective in reducing burnout in psychotherapists?
3. What is the quality of evidence to date in this area and what improvements or gaps can be identified for future research?

Materials and Methods:

This study is reported in accordance with PRISMA guidelines (Page, McKenzie, et al., 2021). A review protocol (**Appendix B**) was created and registered with PROSPERO (registration number: CRD42022329243).

Literature Search Strategy

Database and Source Type Selection

Databases relevant to the current study were initially selected, including EMBASE, MEDLINE, PsychINFO, CINAHL and ASSIA (The University of Edinburgh, 2022). The Scopus database was also included, providing expanded access to conference proceedings (Singh et al., 2021), and a wider range of relevant journals than aforementioned databases combined (APA, 2022; EBSCO, 2022; Elsevier, 2020, 2022; National Library of Medicine, 2022; ProQuest, 2022). The ProQuest Dissertations and Theses Database was also included, as a growing literature emphasis on self-care's importance during psychotherapy training (Barnett et al., 2007; Callan et al., 2020; Miller, 2021) may have increased corresponding graduate and post-graduate research interest in the topic, such that not including dissertations/theses could heighten publication bias (Paez, 2017). Finally, the Cochrane Library Database was included given its importance regarding evidence-based health interventions.

Search Term Selection and Refinement

Initial search terms were considered within population, intervention, comparator and outcome (PICO) categories (Lefebvre et al., 2021; Page, Moher, et al., 2021). Initial population and outcome search terms were based on proposed inclusion criteria and comparable reviews (Simionato & Simpson, 2018; Yang & Hayes, 2020). Given systematic reviews of healthcare should consider

included measures' psychometric properties (Johnston et al., 2022), names of the only five extant burnout measures validated for use in mental health staff and evidencing empirical psychometric support (O'Connor et al., 2018; Shoman et al., 2021) were included as additional outcome terms (see inclusion criteria). As preparatory scoping indicated a lack of controlled studies, no comparator terms were included. Similarly, scoping identified the phrase "self-care" returned mostly irrelevant sources referencing medical self-management (Godfrey et al., 2011). As the term self-care overlaps with many potentially-relevant descriptors (e.g. "career sustaining" or "proactive" behaviours) (Otto et al., 2019; Rupert & Kent, 2007; Vos et al., 2020), no intervention search terms were used to prevent limiting findings through inadvertently omitting obscure terms.

In recognition of the wide range of potentially relevant job titles identified during literature review, several additional population search terms were considered. These could be roughly categorised by their broader role titles, describing various types of "psychologists", "counsellors", "therapists" or "practitioners" (Psychological Professions Network, 2018, 2022). Scoping reviews using terms within these categories found the inclusion of generic "psychologist" and "counsellor" terms captured all related specific job titles (e.g. Clinical Psychologist, Forensic Psychologist, Counselling Psychologist, Person-Centred Counsellor). Conversely, all identified "practitioner" titles (e.g. Education Mental Health Practitioner, Children's Wellbeing Practitioner, Mental Health and Wellbeing Practitioners, Psychological Wellbeing Practitioners) and many more specific "therapist" titles (including Systemic Family Therapist, High Intensity Therapist, Couples Therapist) returned very limited results in the literature, none of which were relevant to the current review. Further, inclusion of the more generic terms "therapist" or "practitioner", to try and capture those delivering psychotherapy, generated significantly larger numbers of results from unrelated professions (e.g. referencing legal, medical or educational practitioners, and occupational or physical therapists).

Following the optimisation strategy outlined by Bramer et al. (2018), scoping searches were conducted to compare results returned using initial outcome and population terms when either including or excluding various specific or generic "practitioner" or "therapist" terms. As the inclusion of all identified "practitioner" terms and most "therapist" terms did not result in additional relevant articles being identified, no "practitioner" terms were retained for the final search. Further, only those "therapist" titles whose inclusion resulted in the identification of additional potentially relevant articles (e.g. Cognitive Behavioural Therapist, Psychological Therapist) were retained.

Thereafter, a wider set of database search terms was identified following recommendations by Bramer et al. (2018). Based on initial PICO terms, appropriate index terms and relevant synonyms were identified in the thesaurus of each respective database where available. Finally, database-appropriate syntax (Boolean operators, parentheses) was used to refine search term lists and account for variations due to language differences and word endings (e.g. plurals). These lists were further augmented following initial scoping results by examining study keywords and abstracts for additional relevant terms, synonyms or spelling variations. The above steps were repeated and translated for each database's distinct search/syntax requirements. Finally, initial search results,

were evaluated to ensure the resulting list of search terms retained were sufficiently broad to sensitively capture populations not specifically named (Bramer et al., 2018). This was achieved using studies identified during the population search term scoping process discussed previously which, while not relevant to the current review aims, would nonetheless be expected to be identified if seeking to more broadly capture the experiences of professionals delivering psychotherapy. These studies all took place in Improving Access to Psychological Therapies (IAPT) services in the UK and used varied and diverse keywords and terms to describe staff delivering psychotherapy (Delgadillo et al., 2018; Steel et al., 2015; Westwood et al., 2017). As each of these sources, and many similar to them, were identified by the final search terms, it was felt these terms were sufficiently sensitive for the purposes of the intended systematic review (Bramer et al., 2018). All search terms used and a worked example of the above process were included in a search strategy document included with the study protocol (**Appendix C**).

Search Methodology

All database searches were conducted in line with the search strategy document (**Appendix C**) on 28th April 2022. Full study text searching was excluded where available based on pilot/scoping searches finding it did not increase identification of relevant studies, despite returning up to 55 times as many search results. Searches were limited by publication date (1st January 1980 onwards to present) as relevant validated outcome measures for burnout were not available prior to this date (Shoman et al., 2021). No further search limitations were imposed.

Reviewers identified additional potentially relevant studies by examining reference lists of book chapters, systematic reviews or meta-analyses identified during searching, and those of studies included for full text review. Further, relevant individuals and organisations identified within these sources were contacted regarding unpublished or ongoing studies.

Regarding included studies, only sources reporting empirical quantitative findings were included. No limitations were placed regarding publication status, geographic location or professional context. Non-English language publications were not excluded at the search stage but were removed during screening if unavailable in English, enabling quantification of potential bias attributable to their removal (Pieper & Puljak, 2021).

Regarding participants, no limitations were placed regarding career stage or qualification status, given the relevance of both self-care and burnout throughout psychotherapist's training and qualified practice (Barnett & Cooper, 2009; Colman et al., 2016; Dorociak, Rupert, & Zahniser, 2017; Kaeding et al., 2017; Simionato & Simpson, 2018). Many professional titles were not included as search terms (e.g. psychiatrists, social workers), given psychotherapy isn't a universally defining characteristic of their role. Studies were however not excluded for including these professionals if evidencing inclusion was due to their routinely delivering psychotherapy. Considering the above, and literature reviewed, inclusion and exclusion criteria were defined as follows:

Participant Inclusion Criteria

- (1) Qualified or pre-qualification psychotherapists (those trained/training in e.g. clinical/counselling psychology or psychotherapy) for whom the central task in their role is delivering psychological therapeutic interventions to promote mental health.

Participant Exclusion Criteria

- (1) Those trained as psychotherapists working in a predominantly academic, administrative, educational or management role, implying significantly less likelihood of routinely delivering psychological interventions.
- (2) Staff for whom the delivery of psychological interventions to promote mental health (as opposed to e.g. educational attainment, independent living, sporting performance) was not the substantive or primary function of the role (e.g. school / college / educational counsellors or psychologists, sports psychologists, genetic counsellors, rehabilitation or vocational rehabilitation counsellors).
- (3) Mixed sample populations including non-psychotherapists (e.g. medical or administrative staff).

Intervention Inclusion Criteria

- (1) Any intervention (defined as an activity or strategy), either cognitive or behavioural in nature, which is or could reasonably be:
 - a. independently, autonomously, and consciously initiated and conducted.
 - b. representative of a conscious effort to foster or interact with additional resources or forms of support.

Intervention Exclusion Criteria

- (1) Any intervention (defined as an activity or strategy), either cognitive or behavioural, that could not reasonably be independently, autonomously or consciously enacted, due to requiring agreement or co-ordination at a team, departmental, management or organisational level (e.g. staff training, group wellbeing interventions, additional line management or supervision).
- (2) Any factor not representative of an actionable cognitive or behavioural intervention (as defined above), including:
 - a. factors measured at a trait level (e.g. optimism/pessimism, self-efficacy, trait mindfulness).
 - b. factors representing persistent individual differences (e.g. age, gender, past experiences of trauma).
 - c. factors outwith individuals' control, especially work or demographic variables (e.g. supervisor's delivery style, hours worked, patient characteristics, gender, past experiences of trauma).
 - d. other individual differences (e.g. personality traits).

- e. subjective evaluative stances (e.g. attributional styles, attitudes, values, beliefs, perceived satisfaction with aspects of workplace or home environment).

Outcome Inclusion Criteria

- (1) Any study that captures burnout as an outcome using one of the five measures demonstrating some empirical evidence of psychometric properties in relevant populations (Shoman et al., 2021). These include the Maslach Burnout Inventory (MBI); Copenhagen Burnout Inventory (CBI); Oldenburg Burnout Inventory (OLBI); the Burnout Measure (BM); and the Psychologists Burnout Inventory (PBI).

Study Selection, Screening and Assessment

The final lists of studies returned from searches were imported into Covidence systematic review software (Veritas Health Innovation, 2022). Duplicates were initially removed via automation, with missed duplicates removed manually by both independent reviewers (the author and a professional peer qualified in psychotherapy).

Remaining studies' titles/abstracts were first screened for relevance and removed or retained for full-text review based on inclusion criteria. Full-text review was undertaken using the same criteria for removal/retention. Studies retained then underwent data extraction and quality analysis.

The first reviewer (author) screened, reviewed, extracted data from, and quality assessed all studies. The second reviewer (psychotherapist peer) screened 62.4% of studies at the title/abstract stage, 22% at full-text review, and completed data extraction and quality assessment for 28% of the final studies selected. Reviewers were initially blinded to each other's decisions, with disagreement resolved at each stage via later discussion.

Data Extraction

Data extraction was conducted prior to quality assessment. Risk of bias was deemed low, given the study aimed to assess the extant literature's methodological quality, and so no exclusion decisions would be required on these grounds (Greenhalgh & Brown, 2017). A data extraction template was created in Covidence using Extraction 2.0 software, with fields selected incorporating guidance for intervention study reviews (T. Li et al., 2022), and relevant items from Cochrane's corresponding template data collection form (Cochrane, 2022). Data captured included studies' methods (e.g. design, recruitment and sampling methods, statistical analysis), participants (demographic and professional characteristics), interventions and outcomes (e.g. measures used, evidence of validity), relevant results, and other study characteristics (e.g. funding, ethics, conflicts of interest) (T. Li et al., 2022).

Quality Assessment

All included studies were observational. A lack of consensus exists regarding appropriate quality assessment tools in such cases (Farrah et al., 2019; Greenhalgh & Brown, 2017; Quigley et al., 2019). Wider recommendations note key potential bias domains should be captured and reported separately (Z. Wang et al., 2019) rather than providing “overall” study bias scores (Losilla et al., 2018; Savitz et al., 2019; Viswanathan et al., 2012). Bias domains noted as critical in observational studies include confounding, selection, information/measurement, reporting and ethics (Sterne et al., 2022; Z. Wang et al., 2019). Checklists are further recommended over scales (Mueller et al., 2018; Sanderson et al., 2007).

Extant reviews (Farrah et al., 2019; Hootman et al., 2011; Sanderson et al., 2007) and regularly-updated web-based directories (Ledbetter & Hendren, 2022) were consulted, identifying the Quality of Survey Studies in Psychology Checklist (Q-SSP) (Protogerou & Hagger, 2020) as the only tool meeting recommendations outlined previously, and displaying evidence of validation and reliability. It was further created expressly to measure psychological survey-based research of the kind exclusively identified by this review. Using the Q-SSP, studies achieve ratings of “acceptable” or “questionable” for each quality assessment domain and overall.

As recommendations noted consideration be given to tools’ duration and ease of use (Hootman et al., 2011; West et al., 2002) to minimise reporting and assessment error (Quigley et al., 2019), the Q-SSP was shortened and modified for use in the present review. Scoring criteria, item changes made and their rationale are outlined in **Appendix D**.

Inter-rater Reliability

Cohen’s Kappa (κ) displays significant sensitivity to distributional skew if most agreed ratings fall into one category, as expected during study screening (mostly exclude) (Cicchetti & Feinstein, 1990; Gwet, 2008; Vach, 2005). The G statistic (Holley & Guilford, 1964) was therefore chosen having been identified as best among a range of equivalent statistics to protect against chance agreement while retaining minimal sensitivity to distributional skew, regardless of rater bias and sample size (Xu & Lorber, 2014). For additional transparency, inter-rater agreement is reported in terms of measured inclusion (p_{POS}), exclusion (p_{NEG}), and total percentage agreement (Cicchetti & Feinstein, 1990; Xu & Lorber, 2014). As both G and κ statistics are described by equivalent statistical formulations (Xu & Lorber, 2014), interpretation follows guidelines recommended by Landis & Koch (1977).

Title and abstract screening showed almost perfect inter-rater agreement (Proportionate agreement 93%, $G=.87$), particularly regarding exclusion ($p_{NEG}=.96$). Inclusion agreement was lower ($p_{POS}=.53$), due mostly to ambiguous language in study titles/abstracts regarding job titles (e.g. “counselor”) and interventions (e.g. state or trait level measurement). Reviewers agreed all ambiguously described studies disputed for inclusion would progress to full-text screening to avoid removing potentially relevant studies.

Inter-rater agreement after full-text screening showed moderate agreement (proportionate agreement 77.8%, $G=.56$), based again on high exclusion agreement ($p_{NEG}=.87$), and greater inclusion disagreement ($p_{POS}=.33$). Disagreement was however based on very few disputed studies ($n=4$), displaying the same language ambiguities, with disputes successfully resolved via discussion.

Data extraction and quality assessment showed almost perfect (proportionate agreement 94.9%, $G=.90$, $p_{NEG}=.88$, $p_{POS}=.97$) and substantial agreement respectively (Proportionate agreement 89.9%, $G=.80$, $p_{NEG}=.90$, $p_{POS}=.90$).

Results

Overview of Study Selection

Figure S1 outlines all systematic search and screening processes. Initial searching identified 837 records, with 238 duplicates automatically removed by Covidence. Reviewers removed 517 studies during title and abstract screening. Nine studies were unavailable for full-text review despite the review teams' best efforts, one due to being unavailable in English. Full-text review of 76 remaining studies identified three further records by manually searching reference lists. No additional sources were identified via other means. Full-text review excluded 58 studies for lacking an intervention variable ($n=32$), participant population ($n=5$) or study design ($n=5$) meeting inclusion criteria. Further, five studies were removed as duplicates not previously identified, and 11 were excluded for meeting multiple exclusion criteria. The final review included 18 studies. All excluded studies and exclusion reasons are outlined in **Appendix E**.

Characteristics of Included Studies

Sample Characteristics:

Summarised study characteristics are presented in **Table S1**. The 18 studies collectively captured responses from 3,447 unique respondents. All studies were conducted in one country only, mostly the USA ($n=13$), with remaining studies conducted in Australia, Canada, Italy, Poland and the UK.

Participants were mostly female (range 53.7% to 95.3%, $M=70.9$, $SD=12.0$). In studies reporting mean ages ($n=15$) and ranges ($n=9$) participants were on average 43.4 years old ($SD=10.8$), or between 19 to 84. Where demographic reporting included ethnicity ($n=14$), for all but one study most participants were white (range 36.4% to 95.5%, $M=77.3\%$, $SD=17.1\%$).

Figure S1: PRISMA 2020 flow diagram for new systematic reviews which included searches of databases and registers only.

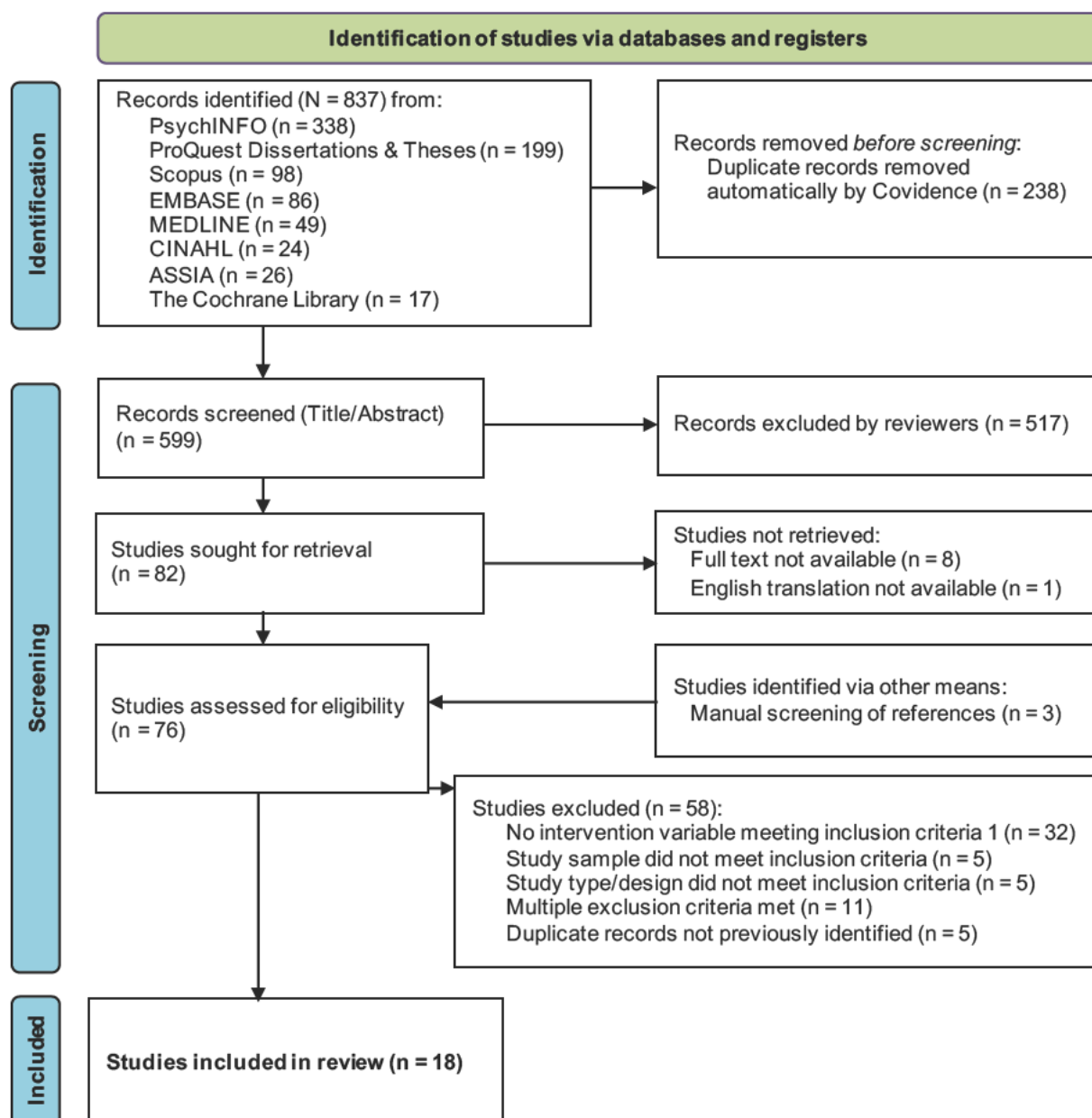


Table S1
Characteristics of Included Studies

Authors (Year) Country	Publication Status	Sample Size (N)	Mean Age (SD) (Range)	% Female	% White	Sampling Approach	Professionals Sampled	Burnout Measure Used	Self-Care Measure Used (Variables Examined)	Statistical Methods & Relevant Study Findings
Adams (2018) USA	Unpublished Dissertation / Thesis	85	35-44 (18-65+)	60.0	36.4	Randomised	Counsellors (of sex offenders)	MBI-HSS	Coping Orientation to the Problems Experienced (COPE) Inventory (Problem-focused coping, Emotion-focused coping).	Bivariate Linear Regression – each IV tested with no covariates or control variables used: <u>Problem-focused & Emotion-focused coping</u> (β) = EE(x), DP(x), PA(x) ($p>.05$).
Cline (2016) USA	Unpublished Dissertation / Thesis	144	(25-65+)	80.6	86.8	Non- randomised	Counsellors (Rural Southern)	MBI-GS (EE subscale only)	Career Sustaining Behaviours Questionnaire (CSBQ). (Total CSBs endorsed)	Bivariate (Pearson's) Correlations: <u>Total CSBs</u> = EE(x) (.08, $p=.34$).
Crescenzo (2021) Italy	Peer- reviewed journal article	468	40.95 (8.98) (26-72)	83.5	NR	Non- randomised	Psychologists (Various)	MBI (Italian)	Coping Orientation to the Problems Experienced (COPE) Inventory (Italian version) (COPE-NVI-25) (Avoidance Strategies, Transcendental Orientation, Positive Attitude, Social Support, Orientation to the Problem).	Bivariate (Pearson's) Correlations (whole sample): <u>Avoidance Strategies</u> = EE(+)** (.39); DP(+)** (.39); PA(-)** (-.37). <u>Positive Attitude</u> = EE(-)** (-.32); DP(-)** (-.29); PA(+)** (.42). <u>Social Support</u> = EE(x) (.01); DP(-)* (-.13); PA(+)* (.14). <u>Orientation to the Problem</u> = EE(-) (-.09); DP(x) (-.05); PA(+)** (.17). <u>Transcendental Orientation</u> = EE(x) (.03); DP(x) (.006); PA(x) (-.00).
										Multivariate Linear Regression (β) – All 5 coping styles as IVs, no other control/covariates. Limited to subsample who voluntarily provided teletherapy during COVID-19 lockdown ($n=239$): <u>Avoidance Strategies</u> (β) = EE(+)** (.42); DP(+)** (.44); PA(-)** (-.31). <u>Positive Attitude</u> (β) = EE(-)** (-.32); DP(-)** (-.33); PA(+)** (.48). <u>Social Support</u> (β) = EE(x) (-.02); DP(-)* (-.18); PA(+)** (.08). <u>Orientation to the Problem</u> (β) = EE(+)* (.18); DP(+)** (.25); PA(-)** (-.13). <u>Transcendental Orientation</u> (β) = EE(x) (-.03); DP(x) (-.04); PA(x) (.05).

Table S1
Characteristics of Included Studies

Authors (Year) Country	Publication Status	Sample Size (N)	Mean Age (SD) (Range)	% Female	% White	Sampling Approach	Professionals Sampled	Burnout Measure Used	Self-Care Measure Used (Variables Examined)	Statistical Methods & Relevant Study Findings
Deters (2008) Canada	Unpublished Dissertation / Thesis	64	48.34 (7.43)	95.3	93.8	Randomised	Counsellors (Specialist - Eating Disorders)	MBI-HSS	Career Sustaining Behaviours Questionnaire (CSBQ). (Total CSBs endorsed, specific CSB items)	Bivariate (Pearson's) Correlations: <u>Total CSBs</u> = EE(x); DP(x); PA(x). "Trying to maintain a sense of control over work" = PA(+)* (r=.25) "Turning to spiritual beliefs" = EE(+). (.31). "Turning to spiritual activities" = EE(+). (.31). "Attending religious services/spiritual support groups" = EE(+)* (.34, p<.01); DP(+). (.31).
Dorociak (2017) USA	Peer- reviewed journal article	422	50.48 (14.50)	69.9	87.8	Randomised	Psychologists (Various)	MBI-HSS	Self-Care Assessment for Psychologists (SCAP) (Professional Support, Professional Development, Life Balance, Daily Balance, Cognitive Awareness)	Bivariate (Pearson's) Correlations: <u>Professional Support</u> = EE(-) (-.12); DP(-) (-.11); PA(+)* (.22). <u>Professional Development</u> = EE(-)* (-.22); DP(-)* (-.25); PA(+)* (.27) <u>Life Balance</u> = EE(-)* (-.34); DP(-)* (-.24); PA(+)* (.35). <u>Daily Balance</u> = EE(-)* (-.45); DP(-)* (-.21); PA(+)* (.25). <u>Cognitive Awareness</u> = EE(-)* (-.34); DP(-)* (-.34); PA(+)* (.44)
Elliott (2021) USA	Unpublished Dissertation / Thesis	233	42.6 (11.4)	89.0	67.4	Randomised	Clinical social workers, marriage and family therapists, and psychologists.	MBI-HSS	Self-Care Assessment for Psychologists (SCAP) (Professional Support, Professional Development, Life Balance, Cognitive Awareness, Daily Balance)	Bivariate (Pearson's) Correlations (Note: One-tailed): <u>Professional Support</u> = EE(-)** (-.33); DP(-)** (-.27); PA(+)** (.30). <u>Professional Development</u> = EE(-)** (-.39); DP(-)** (-.36); PA(+)** (.38) <u>Life Balance</u> = EE(-)** (-.41); DP(-)** (-.29); PA(+)** (.36). <u>Daily Balance</u> = EE(-)** (-.34); DP(-)** (-.24); PA(+)** (.22). <u>Cognitive Awareness</u> = EE(-)** (-.44); DP(-)** (-.36); PA(+)** (.36)

Table S1
Characteristics of Included Studies

Authors (Year) Country	Publication Status	Sample Size (N)	Mean Age (SD) (Range)	% Female	% White	Sampling Approach	Professionals Sampled	Burnout Measure Used	Self-Care Measure Used (Variables Examined)	Statistical Methods & Relevant Study Findings
Emery (2009) Australia	Peer- reviewed journal article	190	30-39 (20-60+)	71.60	NR	NR	Clinical psychologists	MBI-HSS	Personal Resources Questionnaire (PRQ) (Total Personal Resources Used)	Multivariate Linear Regression - (controlling for age, sex, years of experience, full/part-time work, income, living with children, work setting, caseload mix, and work-related beliefs regarding distress, inflexibility, and control): <i>Total Personal Resources Used (β) =</i> EE(-)** (-.24); DP(x) (-.14); PA(+)** (.33).
Estassi (2009) USA	Unpublished Dissertation / Thesis	37	36.81 (10.80) 26-63	NR	51.0	Non- randomised	Psychotherapists (unspecified, working with families exposed to violence)	MBI-HSS	The Self-Care Awareness Worksheet (physical, psychological, emotional, spiritual, workplace, and professional self-care frequency, self-care balance).	Multivariate Linear Regression (all self-care variables entered as predictors): <i>Frequency (all self-care) (β) =</i> EE(x); DP(x); PA(x). <i>Self-care Balance (β) =</i> EE(x); DP(x); PA(x).
Flournoy (1990) USA	Unpublished Dissertation / Thesis	82	42.9 (24-80)	53.7	78.0	Non- randomised	Clinical Psychologists (66.7%), Counselling Psychologists (33.3%), Marriage, Family and Child Counsellors (7.3%), Other (15.9%).	MBI-HSS	The Ways of Coping Questionnaire (accepting responsibility, confrontive coping, distancing, escape-avoidance, planful problem solving, positive reappraisal, self-controlling, and seeking social support)	Multivariate Linear Regression - (controlling for perceptions re: work, including comfort, pressure, innovation, control, clarity, supervisor support, task orientation, autonomy, peer cohesion, and involvement. Also frequency and severity of stressful life events, and amount and satisfaction re: perceived social support) <i>Accepting Responsibility (β) =</i> EE(x)(-.09); DP(-) (-.18); PA(x)(-.05) <i>Confrontive Coping (β) =</i> EE(x)(-.02); DP(x)(.14); PA(x)(.01) <i>Distancing (β) =</i> EE(x)(.10); DP(x)(.16); PA(x)(-.03) <i>Escape Avoidance (β) =</i> EE(x)(.08); DP(x)(.04); PA(x)(-.10) <i>Planful Problem Solving (β) =</i> EE(x)(.02); DP(x)(.04); PA(+) (.18) <i>Positive Reappraisal (β) =</i> EE(-) (-.19); DP(x)(-.03); PA(+) (.21) <i>Self-controlling (β) =</i> EE(x)(.00); DP(x)(.13); PA(x)(.09) <i>Seeking Social Support (β) =</i> EE(x)(-.13); DP(x)(-.03); PA(x)(.16)
Kotera (2021) UK	Peer- reviewed journal article	106	47.42 (14.00) (22-75)	78.3	NR	Non- randomised	Psychotherapists (unspecified)	MBI (2-item version)	Work-Life Balance Checklist (WLBC) (Work-life Balance)	Bivariate (Pearson's) Correlations: <i>Work-life Balance =</i> EE(-)* (-.47); DP(-)* (-.35). Multivariate Linear Regression - (controlling for age, gender, weekly working hours, trait self-compassion and telepressure): <i>Work-life Balance (β) =</i> EE(-)** (-.48); DP(-) (-.36). (Note – strongest predictor of EE/DP in study)

Table S1
Characteristics of Included Studies

Authors (Year) Country	Publication Status	Sample Size (N)	Mean Age (SD) (Range)	% Female	% White	Sampling Approach	Professionals Sampled	Burnout Measure Used	Self-Care Measure Used (Variables Examined)	Statistical Methods & Relevant Study Findings
Nissan (2021) USA	Unpublished Dissertation / Thesis	175	44.4 (26-84)	71.4	86.3	Non- randomised	Healthcare psychologists	The Oldenburg Burnout Inventory (total score)	Social Support Seeking Scale (Seeking Informal & Formal Social Support).	Bivariate (Pearson's) Correlations: <u>Total Support Seeking</u> = TB(x) (-.08, p>.05) <u>Formal Social Support Seeking</u> = TB(x) (-.01, p>.05) <u>Informal Social Support Seeking</u> = TB(x) (-.13, p>.05)
Richards (2018) USA	Unpublished Dissertation / Thesis	154	50.31 (14.48) (19-75)	74.7	83.8	Non- randomised	Counsellors	MBI-HSS (total score)	Self-care Inventory (unnamed) (frequency and perceived importance of physical, psychological, and spiritual self-care, and support from others,).	Multivariate Linear Regression - (controlling for age, gender, ethnocultural background, hardiness, years of experience, job satisfaction, education level, licensure status, and treating trauma as a primary speciality): <u>Frequency of Self-care (Total) (β)</u> = TB(+) (.15). <u>Importance of Self-care (Total) (β)</u> = TB(x) (-.08).
Roper- Ericson (2002) USA	Unpublished Dissertation / Thesis	95	41-50 (20-62)	65.3	80.0	Non- randomised	Counsellors	MBI-HSS	Personal Resources Questionnaire (PRQ) (Recreational Coping, Self-care Coping, Social Support Coping, Rational/Cognitive Coping)	Bivariate (Pearson's) Correlations: <u>Recreational Coping</u> = EE(-)** (-.37); DP(x) (.16); PA(x) (.16). <u>Self-Care Coping</u> = EE(-)* (-.25); DP(x) (-.15); PA(x) (.05) <u>Social Support Coping</u> = EE(-) (-.21); DP(x) (-.14); PA(+)* (.26). <u>Rational / Cognitive Coping</u> = EE(-)** (-.40); DP(-)* (-.26); PA(x) (.09). Multivariate Linear Regression (β not provided) - (all PRQ subscales entered simultaneously in regression model): <u>All PRQ Subscales</u> = EE** (Adjusted R^2 =.164); PA (Adjusted R^2 =.060); DP(x).

Table S1
Characteristics of Included Studies

Authors (Year) Country	Publication Status	Sample Size (N)	Mean Age (SD) (Range)	% Female	% White	Sampling Approach	Professionals Sampled	Burnout Measure Used	Self-Care Measure Used (Variables Examined)	Statistical Methods & Relevant Study Findings
Bivariate (Pearson's) Correlations: <i>Total CSBs</i> = EE(x) (-.01); DP(-)* (-.12); PA(+)* (.30)										
Additional Findings (no supporting statistics reported): - CSBs significantly linked to lower EE & DP = <i>maintaining sense of control, reflecting on satisfying work experiences, maintaining self-awareness/self-monitoring.</i> <i>Maintaining a balance between personal and professional lives</i> = significantly linked to lower EE <i>Maintaining professional identity/values</i> = significantly linked to lower DP - CSBs significantly linked to higher EE = <i>discussing work frustrations with spouse/colleagues, seeking informal support from colleagues.</i> 15 of 25 CSBs were significantly positively related to PA										
Rzeszutek (2014) Poland	Peer-reviewed journal article	200	35.94 (8.05) (26-60)	55.5	NR	NR	CBT and Gestalt Psychotherapists.	The Oldenburg Burnout Inventory (total score)	Berlin Social Support Scale (BSSS) (Support Seeking)	Bivariate (Pearson's) Correlations: Support Seeking did not significantly correlate with total OLBI burnout score (.06, p>.05)
Santana (2017) USA	Peer-reviewed journal article	232	28	73.0	69.0	NR	Clinical, Counselling, or blended Psychology Doctoral Trainees.	MBI-HSS	Self-Care Behavior Inventory (SCBI). (Total self-care over three domains: Cognitive-Emotional- Relational, Physical & Spiritual)	Bivariate (Pearson's) Correlations: <i>Total self-care</i> = EE(-)** (-.13); DP(x) (.10); PA(+) (.25).
Shoyer (1998) USA	Unpublished Dissertation / Thesis	89	45.5 (9.5) (27-71)	56.2	95.5	Non- randomised	Psychotherapists (Counselling - 74.2%, Clinical - 21.3%, Other - 4.4%)	MBI-HSS	The Psychotherapist Self-Care Measure (PSCM) (Objective variables = self-care frequency, variety, and breadth. Subjective variables = perceived self-care helpfulness & importance. Self-care completeness = combined objective & subjective factors).	Bivariate (Pearson's) Correlations: <i>Self-care Completeness</i> = EE(-)* (-.27); DP(-)* (-.30); PA(+)* (.31). <i>Self-care Frequency</i> = EE(x) (-.18); DP(x) (-.17); PA(x) (.23). <i>Self-care Variety</i> = EE(x) (.01); DP(x) (-.08); PA(x) (.05).

Table S1
Characteristics of Included Studies

Authors (Year) Country	Publication Status	Sample Size (N)	Mean Age (SD) (Range)	% Female	% White	Sampling Approach	Professionals Sampled	Burnout Measure Used	Self-Care Measure Used (Variables Examined)	Statistical Methods & Relevant Study Findings
Bivariate (Pearson's) Correlations (Note: One-tailed):										
<u>Recreational Coping</u> =										
EE(-)** (-.48); DP(-)* (-.30); PA(x) (.16).										
<u>Self-Care Coping</u> =										
EE(-) (-.25); DP(-)** (-.39); PA(+)** (.36).										
<u>Social Support Coping</u> =										
EE(-)** (-.52); DP(-)** (-.46); PA(+)* (.29).										
<u>Rational / Cognitive Coping</u> =										
EE(-)** (-.38); DP(-)** (-.35); PA(+)* (.29)										

Note. Table includes only relevant statistical results which were reported within each respective study. Variability of information provided is therefore a result of reporting variations between studies and not deliberate omission. Where possible, specific values are reported.

Key: MBI-HSS = Maslach Burnout Inventory Human Services Survey; MBI-GS = Maslach Burnout Inventory General Survey; EE = MBI Emotional Exhaustion subscale score; DP = MBI Depersonalisation subscale score; PA = MBI Personal Accomplishment subscale score; TB = total burnout score (combining measure subscales); CSBs = Career Sustaining Behaviours.

(x) = No significant relationship with independent variable.

(+) = significant positive relationship with independent variable.

(-) = significant negative relationship with independent variable.

Bold = result significant at $p < .05$ level

* = result significant at $p < .01$ level

** = result significant at $p < .001$ level

Studies mostly included counselling psychologists/counsellors ($n=8$), qualified psychotherapists (unspecified/mixed) ($n=4$), psychologists (unspecified) ($n=2$), and marriage and family therapists ($n=2$). Remaining professional populations were explored in only one study, including trainee psychotherapists (unspecified), healthcare psychologists, clinical psychologists, clinical social workers, and clinical, counselling, and mixed psychotherapy trainees. Studies mostly sampled participants from community-based or outpatient services ($n=14$), inpatient, hospital or residential settings ($n=12$), group or independent private practice ($n=9$), educational establishments ($n=4$), non-profit organisations ($n=1$), prisons ($n=1$) and acute crisis services ($n=1$). Three studies did not report participants' work settings.

Study Characteristics

Most studies ($n=11$) were unpublished theses, with all others ($n=7$) published in peer-reviewed journals. All studies used cross-sectional study designs, with most ($n=11$) only exploring bivariate relationships (correlations) between self-care and burnout.

Most studies ($n=13$) used the Maslach Burnout Inventory Human Services Survey (MBI-HSS) as specified, utilising all three subscales: Emotional Exhaustion (EE), Depersonalisation (DP), and Personal Accomplishment (PA). One study combined MBI-HSS subscale scores to measure "total" burnout. Remaining studies used an Italian MBI translation ($n=1$), a two-item MBI short form ($n=1$), or the Maslach Burnout Inventory General Survey (MBI-GS, designed for broader occupational groups) using only the EE subscale (Cline, 2016). Remaining studies used The Oldenburg Burnout Inventory (OLBI), either using original (Nissan, 2021) or Polish (Rzeszutek, 2014) versions, though both calculated total burnout rather than subscale scores.

Self-care was mostly measured by respondents' frequency using cognitive or behavioural strategies, either within subdomains ($n=7$) or as total combined scores ($n=5$). Measures capturing total self-care included the Career-Sustaining Behaviours Questionnaire (CSB-Q) (Stevanovic & Rupert, 2004), the Self-Care Behaviour Inventory (SCBI) (Santana, 2017), and the Personal Resources Questionnaire (PRQ) (Osipow, 1998). Measures used to capture self-care subdomains included the PRQ, the Self-Care Assessment for Psychologists (SCAP) (Dorociak, 2017), the Ways of Coping Questionnaire (WCQ) (Folkman & Lazarus, 1988), and both the original English Coping Orientation to the Problems Experienced (COPE) Inventory (Carver et al., 1989), and an Italian version with a revised factor structure (COPE-NVI-25) (Foà et al., 2015; Sica et al., 2008).

Specific self-care strategies were measured using the Polish translation (Łuszczynska et al., 2006) of the support seeking subscale from the Berlin Social Support Scale (BSSS) (Schulz & Schwarzer, 2003), a proprietary Social Support Seeking Scale (Nissan, 2021), and the Work-Life Balance Checklist (WLBC) (Daniels & Carraher, 2000).

Three studies used measures capturing additional self-care variables. The Self-Care Awareness Worksheet (Saakvitne & Pearlman, 1996) captured self-care frequency and balance. Two proprietary measures respectively captured self-care frequency and its perceived importance (Richards, 2018), and objective (frequency, variety and breadth of strategies used), subjective (perceived usefulness, importance) and “complete” self-care (incorporating both objective/subjective measures) (Shoyer, 1998).

Proposed Theoretical Mechanisms

Very few ($n=4$) studies cited theoretical mechanisms. Richards (2018) cited Hardiness Theory (Gentry & Kobasa, 1984) and Adams (2018) referenced the theory of cognitive appraisal and coping described by Folkman & Lazarus (1988). Both theories propose burnout is prevented by reappraisal of stressors via adaptive coping behaviours. Flournoy (1990) also cited Folkman & Lazarus (1988), among other theoretical frameworks conceptualising stressors as demands leading to burnout (Maslach & Jackson, 1981; Selye, 1976), and self-care strategies as resources meeting these demands (Sarason et al., 1983). Zeidan-Lukacs (2013) cited the transtheoretical model of behaviour change (Prochaska & Velicer, 1997), noting social support promotes positive behaviour changes, preventing burnout, and Resiliency Theory (Greene et al., 2008; Kaplan et al., 1996), proposing self-awareness/reliance as personal resources preventing stressors contributing to burnout. Remaining studies broadly aligned with burnout, JD-R and COR theories, with self-care strategies conceptualised as personal resources mitigating various demands to prevent burnout.

Quality Assessment of Included Studies

The quality assessment of included studies is visually summarised in **Appendix F** and described below.

Information and Measurement Bias

Only five studies demonstrated acceptable quality for this domain, representing a comparative weakness amongst those reviewed. All defined and justified examined variables, however only five evidenced validity for measures chosen. Only five studies detailed their data collection process sufficiently to demonstrate low measurement bias risk, with less than half ($n=7$) reporting sample size regarding statistical power. Four studies (Deters, 2008; Estassi, 2009; Flournoy, 1990; Zeidan-Lukacs, 2013) reported sample sizes likely insufficient for stated analytical approaches, threatening inference (Maxwell, 2004).

Though not considered by quality assessment criteria, three studies (Cline, 2016; Deters, 2008; Rupert, 2007) used the CSBQ to quantify self-care behaviours. However, the CSBQ asks respondents how important they perceive behaviours to be in helping them. As previously evidenced, awareness of self-care is potentially insufficient to ensure psychotherapists' enactment (Guy et al., 1989; Pope et al., 1987; Sherman, 1996). The CSBQ consequently potentially lacks face validity in psychotherapists.

Selection Bias

Twelve studies demonstrated acceptable quality for this domain, representing a comparative strength amongst studies reviewed. All studies clearly stated inclusion criteria, and most defined and justified populations sampled ($n=15$), and described key sample demographics ($n=12$). However, most studies ($n=11$) insufficiently detailed recruitment strategies. Information provided showed most studies ($n=10$) used convenience/snowball sampling methods, likely introducing selection bias (Barker et al., 2016). Some studies however compensated via randomised selection of participants from psychotherapist registries ($n=6$).

Reporting Bias

Eleven studies demonstrated acceptable reporting quality, representing a comparative strength amongst studies reviewed. However, most ($n=12$) fully reported only significant results. Further, five studies included additional post-hoc statistical tests potentially risking increased false-positives (Simmons et al., 2011). Most post-hoc tests explored additional factors irrelevant to this review. Crescenzo (2021) however altered proposed analyses relating self-care and burnout, specifically due to observed sample differences in these variables, suggesting possible bias.

Ethical Bias

Only three studies demonstrated acceptable quality for this domain, representing the greatest comparative weakness amongst studies reviewed. Only four studies reported on conflicts of interest, including via funding sources. Eight studies further did not report obtaining informed consent from participants, with only one reporting debriefing participants.

Confounding Bias

Only five studies attempted to account for potentially confounding variables, representing a comparative weakness amongst studies reviewed. Shoyer (1998) achieved this via statistical analysis prior to hypothesis testing, finding no differences in self-care and burnout due to possible confounders (e.g. age, gender). Most studies however ($n=4$) accounted for confounders via multiple regression techniques.

Summarised Overall Quality of Included Studies

Only three studies demonstrated overall acceptable quality, with three narrowly missing the acceptability threshold ($>70\%$ quality assessment items endorsed). Remaining studies endorsed 58.8% ($n=4$), 52.9% ($n=3$), 41.1% ($n=2$), or 35.3% ($n=3$) of quality indicator items. Only Kotera et al. (2021) demonstrated acceptability in four domains (excluding information and measurement bias). Remaining studies demonstrated acceptable quality in three domains ($n=6$), two ($n=4$), or only one ($n=3$). Three studies demonstrated questionable quality for all five domains assessed. To better represent and interpret this variability during synthesis, three additional quality subcategories were determined: (1) “almost-acceptable”, missing the acceptability threshold by one item; (2) “questionable”, those requiring multiple additional criteria be met to achieve acceptable quality, yet met more than 50% overall; (3) “highly questionable”, meeting less than 50% of criteria.

Assessment of Possible Outcome Moderators

Study Population

Study population is a likely outcome moderator (Popay et al., 2006). In the present study, populations were categorisable as counsellors, psychologists or mixed/unspecified psychotherapists. Studies examining counsellors reported equal numbers of studies with significant ($n=2$) or non-significant ($n=2$) findings relating burnout and self-care. However, studies exclusively of psychologists or mixed/unspecified psychotherapists reported 4:1 and 2:1 ratios of significant/non-significant findings respectively, indicating study population possibly moderated outcome. Notably, psychologists were the most common sample population in published studies ($n=5$), followed by mixed psychotherapists ($n=2$).

Publication Status

All but one published study found significant relationships between burnout and self-care. By contrast, nearly half of unpublished studies reported no significant findings. Notably, this appears unattributable to study quality, being slightly higher for unpublished studies (57.7%) than published studies (51.2%) (percentage Q-SSP criteria met). This indicates publication status possibly moderated outcome.

Factor Structure of Measures Used

Half the studies reviewed used measures to calculate total self-care scores, or otherwise used broader subscales encapsulating divergent interventions. Most returned non-significant results ($n=5$) or observed only weak significant relationships between burnout and self-care ($n=4$) regardless of study quality. The other half used multi-factorial measures capturing distinct, conceptually congruent self-care categories, mostly ($n=5$) instead finding significant relationships with more moderate effect sizes. Notably, studies finding few/no significant relationships ($n=4$) either used measures displaying significant methodological limitations or combined burnout scores when measures used (OLBI) were multi-factorial, or were statistically underpowered (Flournoy, 1990).

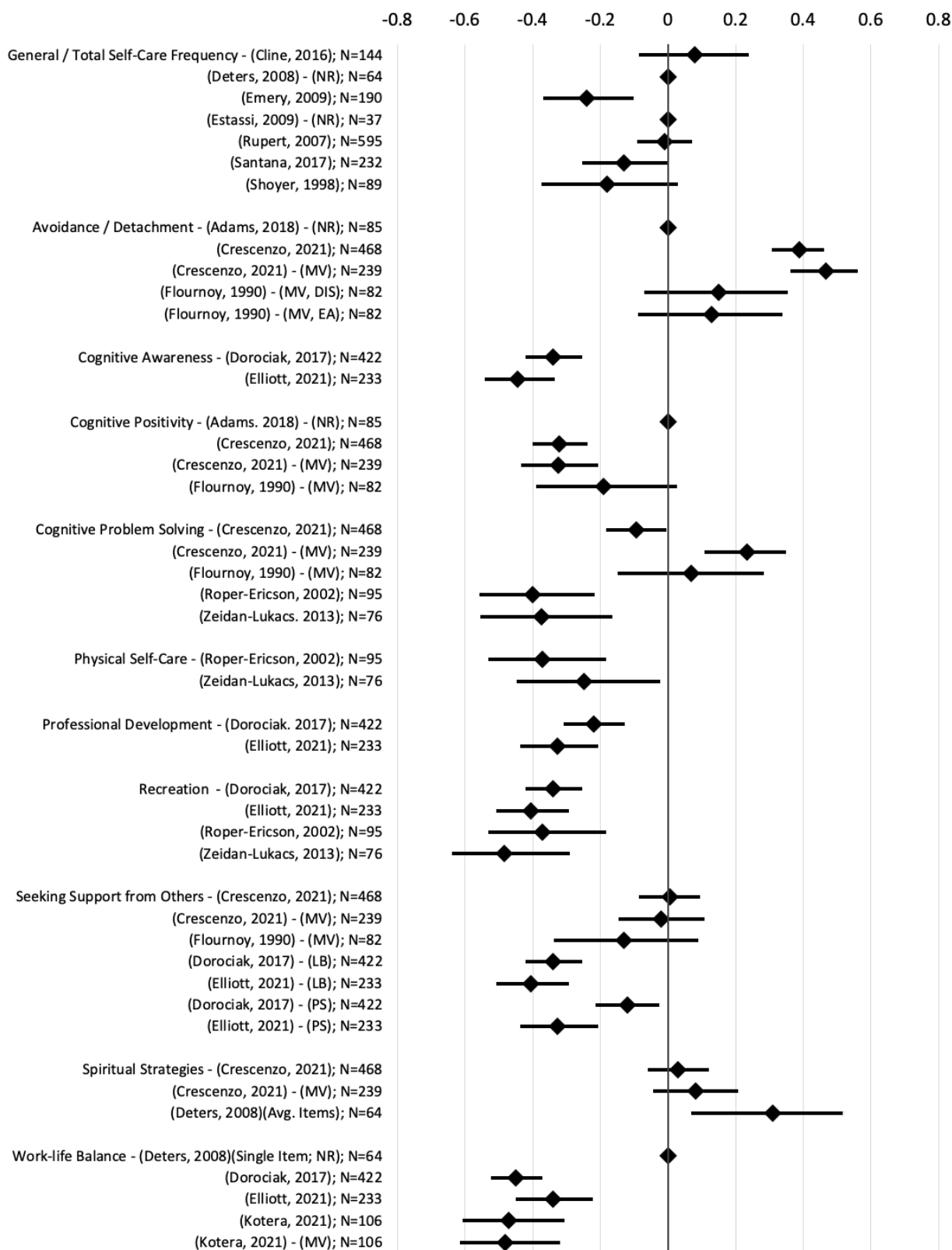
Synthesis of Study Findings

As data extraction and quality assessment identified inconsistent result reporting across studies, and heterogeneity of both findings and variables were observed, a meta-analysis was not performed (Borenstein et al., 2021; Greenhalgh & Brown, 2017).

A narrative synthesis was instead conducted by first categorising overlapping self-care interventions captured across more than one study. Findings for each category are discussed separately below, and visualised on forest plots corresponding to each MBI burnout subscale (EE, DP, PA) (**Figures S2 to S4**).

Figure S2.

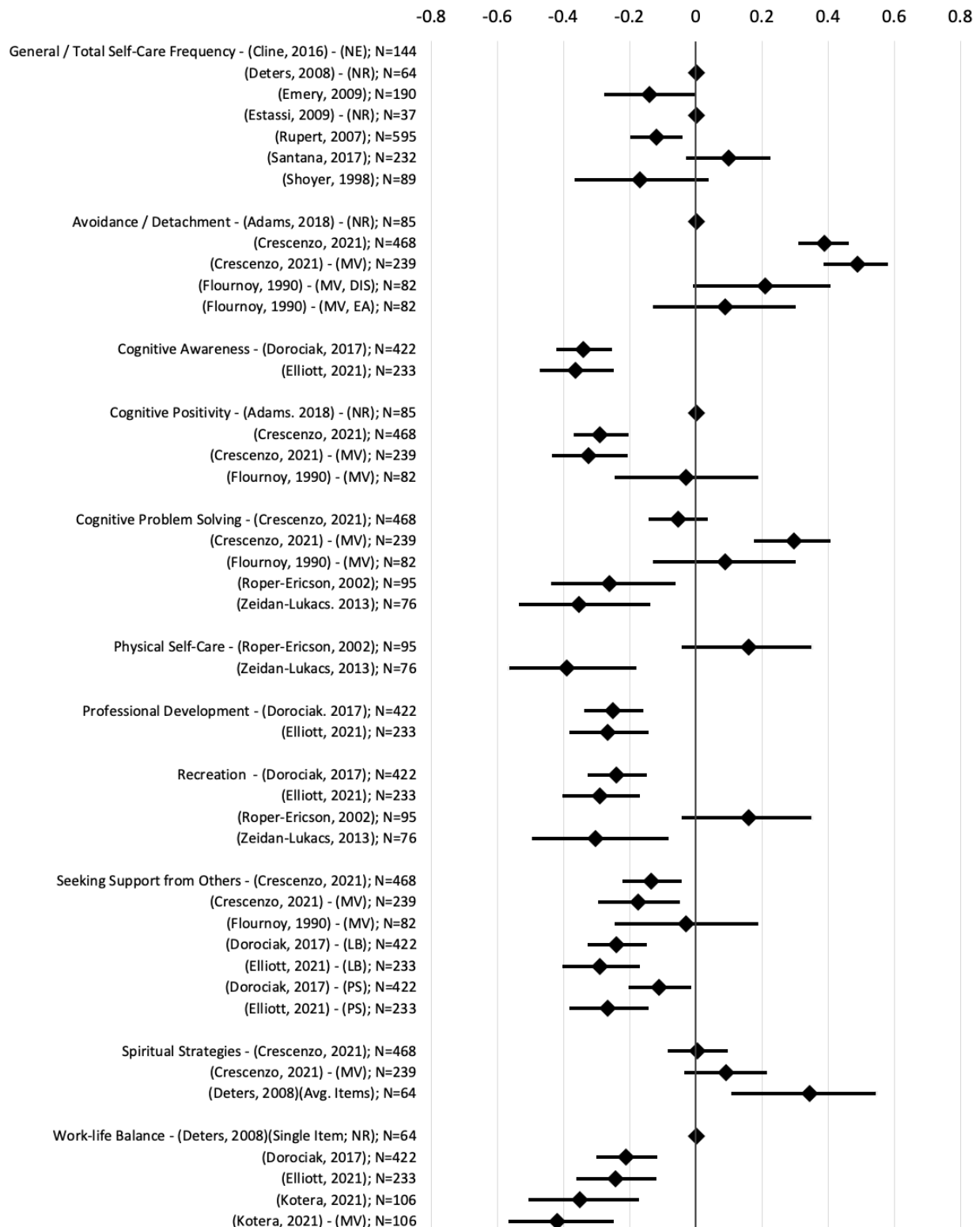
Forest plot of correlation coefficients relating all self-care domains to MBI burnout (emotional exhaustion)



Key. NR = Value not reported by study; MV = Value represents multivariate regression coefficient (β), converted to Pearson's r ; DIS/EA = Values attained using "Distancing" or "Escape / Avoidance" WCQ subscales respectively; LB/PS = Values attained using "life balance" and "professional support" SCAP subscales respectively; Single/Avg. Item(s) = Result based on single scale item or averaged combination of individually-reported scale items in study respectively.

Figure S3.

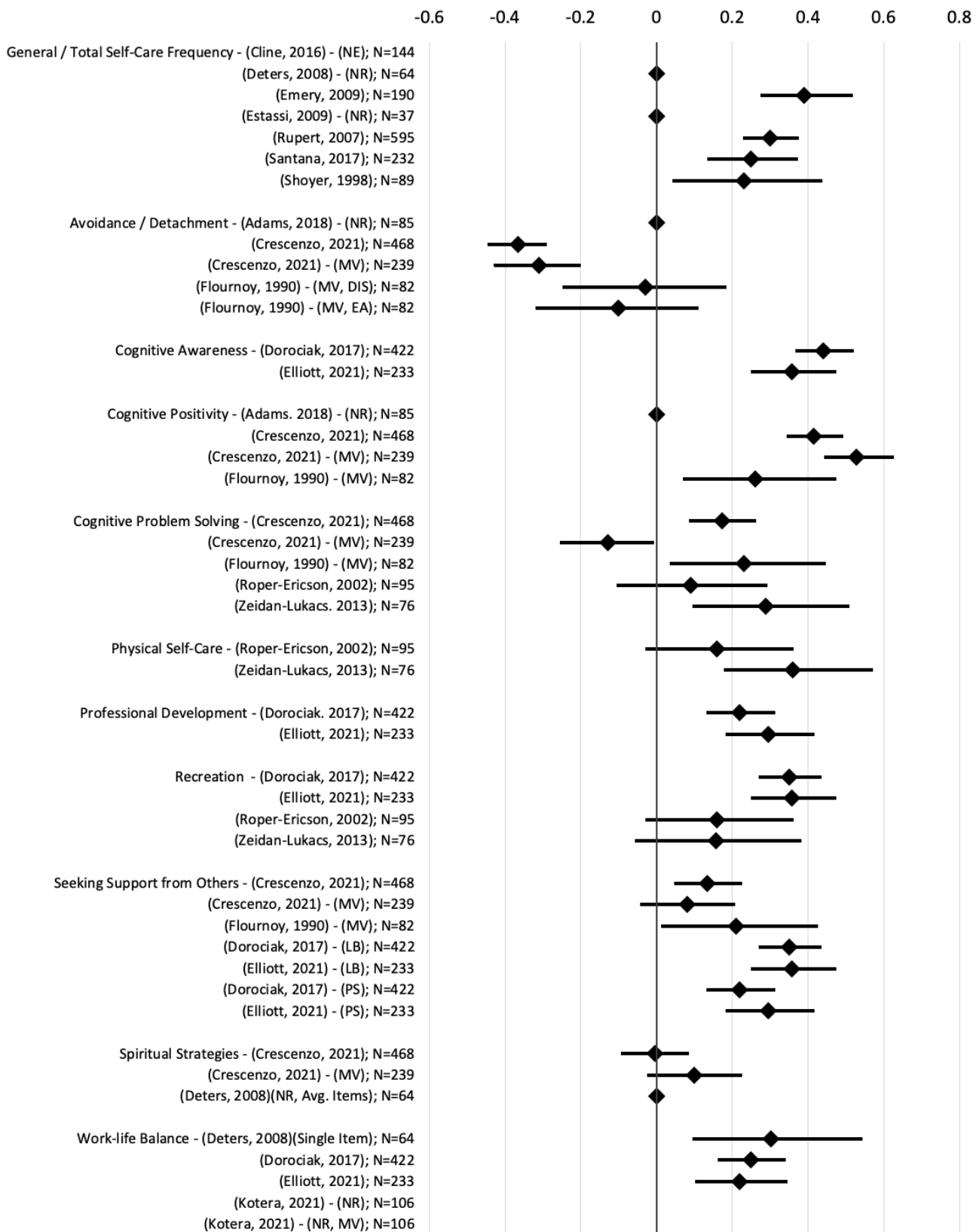
Forest plot of correlation coefficients relating all self-care domains to MBI burnout (depersonalisation)



Key. NE = MBI subscale not explored by study; NR = Value not reported by study; MV = Value represents multivariate regression coefficient (β), converted to Pearson's r ; DIS/EA = Values attained using "Distancing" or "Escape / Avoidance" WCQ subscales respectively; LB/PS = Values attained using "life balance" and "professional support" SCAP subscales respectively; Single/Avg. Item(s) = Result based on single scale item or averaged combination of individually-reported scale items in study respectively.

Figure S4.

Forest plot of correlation coefficients relating all self-care domains to MBI burnout (personal achievement)



Key. NE = MBI subscale not explored by study; NR = Value not reported by study; MV = Value represents multivariate regression coefficient (β), converted to Pearson's r ; DIS/EA = Values attained using "Distancing" or "Escape / Avoidance" WCQ subscales respectively; LB/PS = Values attained using "life balance" and "professional support" SCAP subscales respectively; Single/Avg. Item(s) = Result based on single scale item or averaged combination of individually-reported scale items in study respectively.

To better facilitate visualisation, maximise use of data, and illustrate findings remaining significant despite controlling for other variables, standardised regression coefficients (β) were converted to comparable Pearson's r values for entry into forest plots, following Peterson & Brown's (2005) technique. Effect sizes are quantified in line with Cohen's (1992) recommended values (.01, .03, and .05, indicating weak, moderate and strong relationships respectively). Relationships were classed significant considering observed 95% confidence intervals and reported p -values.

For visual parsimony, some findings are referenced in the text only, including those for self-care variables discussed in only one study, and using combined burnout scores. Similarly, while two studies reported significant relationships between individual self-care measure items and burnout (Deters, 2008; Rupert, 2007), only one provided statistical information (Deters, 2008). The findings reported by Rupert (2007) are therefore referenced in text only, considered complimentary but separate to synthesis.

General Use of Self-care

Seven studies of questionable ($n=5$) and highly questionable ($n=2$) quality assessed mostly bivariate ($n=5$) relationships between overall self-care and burnout. Studies sampled psychologists ($n=3$), counsellors ($n=2$) and mixed/unspecified psychotherapists ($n=2$). Most were unpublished theses ($n=4$). Two studies were statistically underpowered (Deters, 2008; Estassi, 2009), and three used the CSBQ (Cline, 2016; Deters, 2008; Rupert, 2007), indicating potentially reduced face validity.

Most studies found no significant relationships between self-care and either EE ($n=5$) or DP ($n=4$). Emery (2009) found a weak-to-moderate negative relationship between total PRQ self-care and EE when controlling for several potential confounding demographic, work-related, and attitudinal variables. Rupert (2007) observed a weak negative relationship between self-care and DP. Four studies observed weak to moderate positive relationships between overall self-care and PA (Emery, 2009; Rupert, 2007; Santana, 2017; Shoyer, 1998). Richards (2018) controlled for various personal and work-related variables, observing no significant relationship between burnout and self-care importance, though found total self-care frequency positively weakly related to burnout.

Avoidance/Detachment

Three studies of acceptable (Adams, 2018), questionable (Flournoy, 1990) and highly questionable (Crescenzo, 2021) quality related avoidance/detachment and burnout in counsellors, mixed/unspecified psychotherapists, and psychologists respectively. Only Crescenzo (2021) was published, though displayed questionable quality in all domains. Further, Flournoy's (1990) sample size was insufficient to conduct suitably-powered multivariate hypothesis testing (Erdfelder et al., 2009).

Crescenzo (2021) and Flournoy (1990) defined avoidance/detachment as cognitive or behavioural attempts to ignore, minimise or deny stressful events' threats, or otherwise divert attention or detach from them. Interventions were captured either using combined ("Avoidance

Strategies”; Crescenzo, 2021) or separate subscales (“Escape-Avoidance” and “Distancing”; Flournoy, 1990). Adams (2018) investigated the broader domain of emotion-focused coping, comprising avoidance items but also other divergent interventions (e.g. acceptance of responsibility, positive appraisal) (Lazarus & Folkman, 1987).

Crescenzo (2021) found moderate relationships between avoidance/detachment and burnout, correlating positively with EE/DP, and negatively with PA. Multivariate effect sizes were slightly stronger for EE/DP, and weaker for PA, when controlling for other self-care interventions used. These analyses were however conducted in a potentially biased subset of respondents. No other significant relationships between avoidance/detachment and burnout were observed, apart from by Flournoy (1990) who found weak positive multivariate relationships with DP when controlling for various work-related perceptions, stressful life events and social support.

Cognitive Awareness

Two studies of acceptable (Elliott, 2021) and questionable quality (Dorociak, 2017) assessed bivariate relationships between cognitive awareness and burnout, in mixed samples of psychotherapists and psychologists respectively. Only Dorociak (2017) was published. Both studies used the SCAP subscale capturing respondents’ ability/likelihood to self-assess and monitor thoughts and feelings, reactions to others, stress triggers, and efforts to manage workplace challenges. Notably, both studies were among the few to utilise randomised sampling approaches, minimising response bias.

Both studies found significant and universally moderate relationships between cognitive awareness and burnout, correlating negatively with EE/DP, and positively with PA. This aligns with Rupert’s (2007) observation, provided without accompanying statistical information, that “maintaining self-awareness/self-monitoring” was significantly negatively related to EE and DP.

Cognitive Positivity

Three studies of mixed acceptable (Adams, 2018), questionable (Flournoy, 1990) and highly questionable (Crescenzo, 2021) quality related cognitive positivity and burnout in counsellors, mixed/unspecified psychotherapists, and psychologists respectively. Only Crescenzo (2021) was published. As previously noted, Crescenzo (2021) and Flournoy (1990) displayed additional risks due to reporting and information/measurement bias respectively.

Crescenzo (2021) assessed positive attitude, representing containment, proactive acceptance and positive reinterpretation of stressors. Adams (2018) assessed emotion-focused coping, a broad subdomain containing only some items relating to positive reappraisal. Flournoy (1990) explored positive reappraisal, defined as efforts to create positive meaning by focusing on personal growth. Crescenzo (2021) found moderate bivariate and multivariate relationships between cognitive positivity and all burnout subscales, negatively correlating with EE/DP, and positively with PA. Flournoy (1990) found weaker and potentially non-significant results in the same directions for

EE/DP, though found a significant weak-to-moderate positive relationship with PA. Findings broadly align with observations by Rupert (2007) who observed “reflecting on satisfying work experiences” significantly negatively correlated with EE and DP in psychologists.

Cognitive Problem Solving

Four studies of almost-acceptable (Roper-Ericson, 2002; Zeidan-Lukacs, 2013), questionable (Flournoy, 1990), and highly questionable quality (Crescenzo, 2021) assessed mostly bivariate relationships between cognitive problem solving and burnout. Studies sampled counsellors (Roper-Ericson, 2002), mixed/unspecified psychotherapists (Flournoy, 1990; Zeidan-Lukacs, 2013), and psychologists (Crescenzo, 2021). Only Crescenzo (2021) was published. As previously noted, most studies displayed additional risks of reporting (Crescenzo, 2021), and information/measurement bias (Flournoy, 1990; Zeidan-Lukacs, 2013).

Roper-Ericson (2002) and Zeidan-Lukacs (2013) examined “rational/cognitive coping” (PRQ subscale), Crescenzo (2021) explored “orientation to the problem” (COPE-NVI-25 subscale), and Flournoy explored “planful problem solving” (WCQ subscale). Common components captured were respondents’ prioritisation and focus of cognitive effort on analytic and systematic attempts to problem-solve in response to stressors.

Findings were notably mixed. Bivariate relationships observed with EE/DP were either largely insignificant (Crescenzo, 2021), or significant, moderate and negative (Roper-Ericson, 2002; Zeidan-Lukacs, 2013). Multivariate relationships were however positive, displaying significant weak-to-moderate relationships when controlling for other self-care interventions used (Crescenzo, 2021), and weak non-significant relationships when controlling for various work-related perceptions, stressful life events and social support (Flournoy, 1990).

Regarding PA, mostly significant positive weak-to-moderate relationships were observed with cognitive problem solving. Two exceptions were a non-significant weak positive relationship observed by Roper-Ericson (2002), and a weak negative multivariate relationship which emerged when controlling for other self-care interventions used (Crescenzo, 2021).

Physical Self-Care

Two studies of almost-acceptable quality (Roper-Ericson, 2002; Zeidan-Lukacs, 2013) examined physical self-care in counsellors and psychotherapists (mixed) respectively. Both studies used the PRQ “self-care coping” subscale, encapsulating regular and sufficient exercise and sleep, maintaining a good diet, using relaxation techniques, and avoiding harmful substances (e.g., alcohol, drugs, tobacco, coffee). Both studies were unpublished and used bivariate analyses.

Zeidan-Lukacs (2013) observed significant weak-to-moderate relationships between physical self-care and burnout, relating to negatively to EE/DP and positively to PA. Roper-Ericson (2002) however found a significant weak-to-moderate relationship only with EE.

Professional Development

Two studies of acceptable (Elliott, 2021) and questionable quality (Dorociak, 2017) assessed bivariate relationships between professional development and burnout, in mixed samples of psychotherapists and psychologists respectively. Only Dorociak (2017) was published. Both studies used the SCAP subscale capturing self-care via enhancement of knowledge and skills, engaging with relevant professional organizations, and participating in work-related and community events. Again, both studies were among the few to utilise randomised sampling approaches, minimising selection bias.

Both studies found significant bivariate relationships between professional development and all burnout subscales, correlating negatively with EE/DP and positively with PA. Effect sizes observed were either all approximately moderate (Elliott, 2021) or weak-to-moderate (Dorociak, 2017).

Recreation

Four studies of acceptable (Elliot, 2021), almost-acceptable (Roper-Ericson, 2002; Zeidan-Lukacs, 2013), and questionable quality (Dorociak, 2017) examined recreation. Only Dorociak (2017) was published. Studies sampled mixed/unspecified psychotherapists (Elliot, 2021; Zeidan-Lukacs, 2013), counsellors (Roper-Ericson, 2002), and psychologists (Dorociak, 2017).

Studies quantified recreation using either the SCAP subscale “life balance” (Dorociak, 2017; Elliott, 2021), or the PRQ “recreational coping” subscale (Roper-Ericson, 2002; Zeidan-Lukacs, 2013). Both scales capture the use of time outside work for participating in comforting/relaxing or satisfying/enjoyable activities.

Most studies found moderate-to-large bivariate relationships between recreation and EE, and weak-to-moderate relationships with DP. Roper-Ericson (2002) however found a non-significant weak-to-moderate positive relationship with DP. Findings for PA were mixed with half the studies showing moderate-to-large positive relationships with recreation (Dorociak, 2017; Elliott, 2021), and the other half showing non-significant weak-to-moderate positive relationships (Roper-Ericson, 2002; Zeidan-Lukacs, 2013).

Seeking Support from Others

Six studies of mixed acceptable (Elliott, 2021), questionable (Dorociak, 2017; Flournoy, 1990) and highly questionable quality (Crescenzo, 2021; Nissan, 2021; Rzeszutek, 2014) explored relationships between seeking support and burnout. Unpublished studies ($n=3$) sampled mixed psychotherapists (Elliott, 2021; Flournoy 1990) or psychologists (Nissan, 2021). Published studies ($n=3$) sampled psychologists (Crescenzo, 2021; Dorociak, 2017) or mixed psychotherapists (Rzeszutek, 2014).

Studies collectively assessed the seeking of support from both personal and professional sources. Dorociak (2017) and Elliott (2021) used SCAP subscales of “professional support” and “life balance”, capturing efforts to seek/maintain interpersonal support from work colleagues or spend

time with family and friends respectively. Remaining studies used combined scales encapsulating both.

Dorociak (2017) and Elliott (2021) found significant bivariate relationships between both support seeking subscales and all burnout subscales, correlating negatively with EE/DP, and positively with PA. Elliott (2021) found moderate effect sizes for all but the correlation between DP and life balance. Observed effects were consistently larger than those of Dorociak (2017) who found moderate relationships only between EE/PA and life balance. Crescenzo (2021) found weaker bivariate and multivariate relationships in the same directions, significant only for DP and PA. No remaining studies found any significant correlation between seeking social support and burnout. Rupert (2007) additionally reported that “discussing work frustrations with spouse/colleagues” and “seeking informal support from colleagues” significantly positively correlated with EE.

Finally, while the PRQ as used by Roper-Ericson (2002) and Zeidan-Lukacs (2013) captures “social support coping”, subscale items reference the presence of valued others, rather than support seeking. These findings were therefore excluded.

Spiritual Strategies

Crescenzo (2021) found no significant bivariate or multivariate relationships between any burnout subscale and transcendental orientation, a coping style capturing religious and spiritual aspects and activities. Deters (2008) however observed significant positive relationships with moderate effect sizes between several spiritually-relevant career-sustaining behaviours and EE, including “turning to spiritual beliefs”, “turning to spiritual activities” and “attending religious services/spiritual support groups”. The last item further displayed a significant, moderate, positive correlation with DP.

Work-life Balance

Four studies of acceptable (Elliot, 2021; Kotera, 2021) and questionable quality (Deters, 2008; Dorociak, 2017) explored the relationship between work-life balance and burnout. Studies sampled psychotherapists (mixed/unspecified) (Elliot, 2021; Kotera, 2021), counsellors (Deters, 2008) and psychologists (Dorociak, 2017). Both Kotera (2021) and Dorociak (2017) were published.

Kotera (2021) used the WLBC, assessing good/poor work-life balance via item agreement (e.g. “I have to take work home most evenings”). Dorociak (2017) and Elliott (2021) examined SCAP daily balance, representing respondents’ avoiding over-commitment at work (e.g. taking on additional workload), intentionally using relaxation or break time, and balancing work/relaxation overall.

Kotera (2021) examined EE/DP only, observing moderate-to-large negative bivariate relationships between both and work-life balance. These relationships and approximate effect sizes remained consistent under multivariate analysis controlling for demographic (age, gender), work (weekly working hours, telepressure) and trait (self-compassion) variables. Dorociak (2017) and Elliott (2021) both found significant bivariate relationships between daily balance and burnout,

correlating negatively with EE/DP and positively with PA. Effect sizes were moderate for EE in both studies, but slightly weaker for DP and PA.

Deters (2008) similarly reported a weak-to-moderate significant positive relationship between “trying to maintain a sense of control over work” and PA. Rupert (2007) also observed “maintain a balance between personal and professional lives” significantly negatively correlated with EE.

Other Self-Care Factors Examined

Estassi (2009) conducted multiple regression analyses to examine the relationship between burnout and the frequency and balance of respondents’ self-care incorporating multiple interventions (e.g. physical, spiritual). Including all self-care variables as co-variates, no significant relationships were observed.

Shoyer (1998) found no significant bivariate relationships between either self-care frequency or variety and burnout. However, self-care “completeness”, a combination of objective and subjective self-care endorsement, significantly negatively correlated with EE and DP with almost-moderate and moderate effect sizes respectively, and correlated positively and moderately with PA.

Finally, Flournoy (1990) examined several other self-care interventions using the WCQ including self-controlling, confrontative coping and accepting responsibility, finding no significant relationships apart from a weak negative relationship between accepting responsibility and DP.

Summary of Synthesised Findings

Observed findings were considered regarding the amount and quality of evidence, trends replicated across studies, effect size as an indicator of potential practical significance, and possible moderators of outcome. This information is visually summarised in **Table S2**.

Table S2.

Summarised Findings of Included Studies.

Study Name	Adams (2018)	Cline (2016)	Crescenzo (2021)	Deters (2008)	Dorociak (2017)	Elliott (2021)	Emery (2009)	Estassi (2009)	Flournoy (1990)	Kotera (2021)	Nissan (2021)	Richards (2018)	Roper- Ericson (2002)	Rupert (2007)	Rzeszutek (2014)	Santana (2017)	Shoyer (1998)	Zeidan- Lukacs (2013)
Self-Care Variables																		
General/Total Self-care Frequency		X		X			●	X				●		●		●	X	
Specific Self-Care Interventions																		
Avoidance / Detachment	X		□						X									
Cognitive Positivity	X		■											●				
Cognitive Awareness					■	■								●				
Cognitive Problem-Solving			●/○						●				●					■
Recreation					■	■							●					●
Physical Self-Care													●					■
Professional Development					■	■												
Seeking Support from Others			●		■	■			X		X			○	X			
Spiritual Strategies			X	○														
Work-life Balance				●	■	■				■				●				
Study Characteristics																		
Publication Status	T/D	T/D	JA	T/D	JA	T/D	JA	T/D	T/D	JA	T/D	T/D	T/D	JA	JA	JA	T/D	T/D
Measure Used	COPE	CSBQ	COPE-NVI	CSBQ	SCAP	SCAP	PRQ	SCAW	WCQ	WLBC	SSSS	SCI	PRQ	CSBQ	BSSS	SCBI	PSCM	PRQ
Study Population	CO	CO	PS	CO	PS	PT	PS	PT	PT	PT	PS	CO	CO	PS	PT	PS	PT	PT
Sample Size (<i>N</i>)	85	144	468	64	422	233	190	37	82	106	175	154	95	595	200	232	89	76
Bivariate / Multivariate Analysis	BV	BV	BV/MV	BV	BV	BV	MV	MV	MV	BV/MV	BV	MV	BV/MV	BV	BV	BV	BV	BV

Key. Publication Status - T/D = Unpublished Thesis or Dissertation; JA = Published Journal Article; **Measures Used** - BSSS = Berlin Social Support Scale; COPE = Coping Orientation to the Problems Experienced Inventory; COPE-NVI = Coping Orientation to the Problems Experienced Inventory (Italian version); CSBQ = Career Sustaining Behaviours Questionnaire; PRQ = Personal Resources Questionnaire; PSCM = The Psychotherapist Self-Care Measure; SCAP = Self-Care Assessment for Psychologists; SCAW = The Self-Care Awareness Worksheet; SCBI = Self-Care Behaviour Inventory; SCI = Self-Care Inventory; SSSS = Social Support Seeking Scale; WCQ = The Ways of Coping Questionnaire; WLBC = Work-Life Balance Checklist; **Study Population** - CO = Counsellors (Mixed/Unspecified); PS = Psychologists (Mixed/Unspecified); PT = Psychotherapists (Mixed/Unspecified); **Bivariate / Multivariate Analysis** - BV = Study employed only bivariate statistical analyses; MV = Study employed only multivariate statistical analyses; BV/MV = Study employed both bivariate and multivariate analyses. **Colour Coding** - Colours indicate study quality, with green representing “acceptable” quality, and progressively darker colours of pink to red representing “almost acceptable”, “questionable” and “highly questionable” quality respectively.

Significance. ■ = Examined self-care variables were significantly negatively related to all burnout scales/subscales reported in the study, in a pattern suggesting an overall negative relationship with burnout; □ = Examined self-care variables were significantly related to all burnout scales/subscales reported in the study, in a pattern suggesting an overall positive relationship with burnout; ● = Examined self-care variables related significantly but inconsistently to all or only some burnout scales/subscales reported in the study, in a pattern suggesting a negative relationship with burnout; ○ = Examined self-care variables related significantly but inconsistently to all or only some burnout scales/subscales reported in the study, in a pattern suggesting a positive relationship with burnout; X = No significant relationships were found between any self-care variables and any burnout factors reported.

Discussion

This review's aims were to: (1) review and describe extant literature examining consciously-initiated, autonomous self-care in relation to psychotherapists' burnout; (2) identify which interventions may offer utility in addressing burnout; (3) identify possible improvements or gaps for future research based on the findings and quality of reviewed literature.

Summary of Findings

Regarding the first review aim, 18 studies were identified of mostly questionable quality ($n=15$), all using cross-sectional designs limiting causal inference. Studies were mostly unpublished dissertations/theses ($n=11$), conducted in the USA ($n=13$), and sampled mixed/unspecified psychotherapists ($n=7$), relative to psychologists ($n=6$) and counsellors ($n=5$). Sampled participants were mostly female, white, and on average 43 years old. Participants mostly worked, in descending order, in community-based or outpatient facilities, inpatient or hospital settings, group/individual private practice, or other settings (including charitable, education, acute crisis, and prison services). Half the studies explored broad, global measures of self-care, while the other half used multifactorial measures capturing distinct self-care categories. Published studies and those using multi-factorial measures more frequently found significant relationships between burnout and self-care.

Regarding the second review aim, a relationship between work-life balance and burnout received the greatest empirical support, based on comparatively consistent relationship patterns with all burnout subdomains, retained when controlling for potential confounding variables, and observed within the subset of studies demonstrating highest overall quality ($n=4$). Results were further replicated across published and unpublished studies and professional sub-categories, suggesting robustness against publication bias and good generalisability. A relationship between recreation and burnout received the second-most support, based on comparatively moderate and consistent effects observed particularly for EE, and again being based on an overall higher-quality subset of studies ($n=4$) with no critical methodological flaws.

Several other self-care categories were explored in small ($n=2$) but comparatively high-quality subsets of studies. Of these, cognitive awareness appeared best supported given the moderate size of effects observed, and comparative consistency of results in relating to burnout. This was followed by professional development, which showed slightly weaker effect sizes, and physical self-care, which displayed a less consistent pattern of relationships with DP/PA than EE.

Two self-care categories displayed more inconsistent results across larger subsamples including studies of more varied quality. Seeking support from others was evaluated in a comparatively large subset of studies ($n=6$). More consistent relationships with burnout were however observed in higher-quality studies lacking significant methodological limitations, suggesting a potential weak-to-moderate negative relationship between seeking social support and burnout, particularly PA. These observations were repeated regarding cognitive problem solving. Initially

appearing inconclusively related to burnout, the weakest and least congruent results occurred in the studies with the lowest overall quality and noted methodological limitations. Remaining studies suggest a weak-to-moderate negative relationship potentially exists with burnout.

The remaining self-care categories received highly limited support for relating to burnout, based on limited/conflicting evidence from studies of almost exclusively questionable quality. This included the overall use of self-care, cognitive positivity, and other possibly relevant self-care factors (e.g. self-care balance, additional PRQ subscales).

Finally, two self-care categories, avoidance/detachment and spiritual strategies, displayed tentative positive relationships with burnout, though based on limited and low-quality studies.

Interpretation of Findings

Considering findings of the first two review aims, it must be noted some self-care categories were examined in only a few studies of low quality. Given absence of evidence is not evidence of absence, inference is limited regarding comparison between different self-care strategies, based solely on the amount of support available.

With this caveat acknowledged, it remains highly notable that specific self-care categories were more strongly supported as relating to burnout than overall self-care use. This could be attributable to combined “global” self-care measures displaying construct-irrelevant variance (Messick, 1995) when simultaneously capturing multiple divergent interventions. Though partially influenced by study quality, heterogeneity was nonetheless observed across individual self-care categories’ relationships to burnout. These observations collectively appear to contradict assertions that, for psychotherapists, cultivating a broad range is more important than using particular self-care interventions to manage distress (Norcross & VandenBos, 2018b). They also support meta-analytic findings observing self-care related differentially to distinct wellbeing outcomes in trainee psychotherapists (Colman et al., 2016).

Specifically, Colman et al. (2016) reported self-care’s benefits appeared greatest in terms of protective gains (e.g. increased satisfaction with life/studies, mental wellbeing), and lowest in terms of “losses” (e.g. reducing stress)(Colman et al., 2016). This is reflected in the present findings, as observed effect sizes across studies were largest on average for the “gain” of personal accomplishment, and lower for emotional exhaustion and depersonalisation. Considering relevant theories (JD-R, COR), self-care appears more strongly related to increasing personal resources than decreasing demands’ impacts (Demerouti et al., 2001; Hobfoll & Freedy, 1993).

Correspondingly, the self-care categories with the strongest support for relating to burnout, work-life balance and recreation, were those most strongly encapsulating restorative recovery from work (Sonnentag & Fritz, 2007). Reviewed findings therefore align with substantial evidence in the general occupational literature of recovery’s importance for employee wellbeing and performance

(Bennett et al., 2018; Steed et al., 2021; Wendsche & Lohmann-Haislah, 2017). They further support recent theoretical developments to the JD-R model, noting recovery from work as a key to adaptively responding to work demands (A. Bakker & de Vries, 2021), and empirical findings noting this is particularly the case for those risking burnout (Oerlemans & Bakker, 2014), in whom an inability to recover outside work may mark a tipping point towards burnout's development (Leiter & Maslach, 2003).

A key ability in work recovery is psychological detachment, evidenced by an absence of thoughts/pre-occupations with work in non-work time (Sonnentag & Fritz, 2015). This relates to the third-most well supported self-care category in this study, cognitive awareness, which encapsulates self-monitoring and regulative abilities implicated as necessary for psychological detachment (Sonnentag & Fritz, 2015).

Considered collectively, the self-care categories best supported as relating to burnout by this review represent key elements of self-regulation (work-life balance, recreation, professional development, physical self-care)(A. Bakker & de Vries, 2021) and self-awareness (cognitive awareness). This review therefore also potentially supports previous assertions that both self-regulation and self-awareness are principally important components of self-care for psychotherapists (E. Baker, 2003a; Coster & Schwebel, 1997; Dlugos & Friedlander, 2001; Norcross & VandenBos, 2018b). Review findings further extend those in mixed mental health staff populations, where more active self-regulation, through maintaining work-life balance and self-awareness, were related to lower burnout (Ben-Zur & Michael, 2007; Thornton, 1992).

While the self-care categories best-supported by this review emphasise self-aware, proactive planning and maintenance of resources, by contrast, those least-supported represent inherently more reactive interventions, including seeking social support, and cognitive problem solving or positivity. Further, some were even tentatively positively related to burnout (avoidance/detachment, spiritual strategies). While noting this may merely reflect a lack of a comparable amount and quality of evidence relative to other categories, this observation aligns with previous findings that avoidant and reactive coping strategies (e.g. denial, venting, substance use, wishing the situation away) were related to higher burnout in mental health staff (Ben-Zur & Michael, 2007; Thornton, 1992).

In sum, findings align with extensive assertions (E. Baker, 2003a; Bamonti et al., 2014; Barnett et al., 2007; Posluns & Gall, 2019; Rupert et al., 2015; Simionato et al., 2019) and limited empirical findings (Rupert & Dorociak, 2019) noting self-care is likely most effective when enacted proactively and preventatively. However, inference regarding causality is limited by the exclusively cross-sectional designs of included studies. However, consistent with a substantial body of occupational stress theory (Dewe et al., 2012; Kelloway et al., 2008) and related longitudinal evidence (Ford et al., 2014; Guthier et al., 2020; Sonnentag & Frese, 2012), it is expected development of burnout will show a reciprocal relationship with more routine stress over time, with one cumulatively influencing the other. Therefore, regardless of whether certain self-care interventions reduce burnout, or escalating

burnout reduces use of those interventions, as both are possible, the difference in practical application is temporal, differing only in whether interventions are being supported pre-emptively or after being diminished. Both are equally valid for consideration, as each affords an opportunity to break or reverse the likely gradual, chronic and escalating cycles of burnout and impairment (Ford et al., 2014; Guthrie et al., 2020).

With respect to the third review aim, the above findings and their interpretation must be considered regarding limitations observed in the literature and the review itself.

Limitations of Literature Reviewed

Considering the reviewed literatures' methodological quality, the greatest limitations observed concerned ethical, information/measurement, and confounding biases respectively. Regarding ethics, studies failing to confirm informed consent or debriefing of participants imply potential power imbalances between participants and researchers sufficient to risk response bias (BPS, 2021). However, low reporting may be explained by unreported use of implied consent for the web-based or postal surveys (Whitehead, 2007) predominantly utilised. Considering information and measurement, in addition to prevalent use of total burnout and self-care previously discussed, most studies did not consider sample size regarding statistical power, evidence using validated measures, or adequately report data collection procedures. This respectively frustrates meaningful inference (Abraham & Russell, 2008), healthcare stakeholders' confidence in applying findings (Johnston et al., 2022), and much-needed replicability (Tackett et al., 2019). Finally, over-reliance on bivariate statistics limited inference regarding confounding.

Beyond methodological quality, the most apparent limitation of reviewed literature concerned cross-cultural generalisability, with studies conducted exclusively in Western, educated, industrialised, rich and democratic societies. This echoes a bias sadly characteristic of wider research (Henrich et al., 2010), limiting potential generalisability to psychotherapists in countries where psychotherapies are least available and most needed (Fairburn & Patel, 2014; Kohn et al., 2004; Moitra et al., 2022; P. Wang et al., 2007).

Publication bias and professions sampled appeared to further threaten generalisability. Published studies reviewed returned higher proportions of significant results. Studies also mostly sampled mixed/unspecified psychotherapists (39%), followed by psychologists (33%) and counsellors (28%), contrasting notably with larger-scale workforce surveys, in which psychologists tend to predominate (NHS Education Scotland, 2022; NHS Health Education England, 2022c; Orlinsky, 2022). However, these threats appear less concerning, given the self-care intervention categories best-demonstrating relationships with burnout did so across both published/unpublished studies in multiple professional populations.

Limitations of this Review

Beyond included literature, the review itself was subject to further limitations. Several potentially relevant studies were excluded because they were inaccessible to the researchers or not available in English (**Appendix E**). Similarly, requests for unpublished or pre-publication studies relevant to the review were sent comparatively late in the timeframe of project completion, meaning further relevant findings may have been excluded. Study selection was further frustrated by ambiguity regarding inclusion criteria, particularly due to subjective language regarding studies' operationalisations of self-care or interventions being at state or trait levels. An initial pilot review stage followed by full dual review would likely have clarified potentially ambiguous inclusion criteria further, strengthening review findings (McDonagh et al., 2013). Finally, regarding quality assessment, modifying the Q-SSP checklist potentially deflated overall quality ratings, particularly biasing the quality domains identified as weaknesses in the present review. Specifically, items combined regarding information and measurement, and items re-included regarding ethics (despite being dropped by the original creators during development) (Protogerou & Hagger, 2020), may have reduced opportunities for studies to demonstrate methodological quality, while increasing the threshold of acceptable ethical quality respectively.

Strengths of Review Findings

Despite noted limitations, this review and included literature displayed several strengths. Main findings were demonstrated in a broad mix of professionals, across a wide range of public and private service settings, conferring good generalisability and ecological validity. Including grey literature further enabled demonstration findings were robust to publication bias. Additional confidence in findings is conferred by quality assessment encapsulating the critical potential sources of bias in observational studies, using items specifically designed and validated as relevant to the populations and survey methodologies reviewed, in a modified quality measure demonstrating increased stringency (Protogerou & Hagger, 2020). Further, included studies mostly demonstrated acceptable robustness to selection and reporting biases. Considering these strengths, the following points are highlighted regarding future clinical intervention and research.

Clinical Implications

Self-care interventions promoting recovery or disconnection from work being best-supported as relating to burnout mirror the substantially-evidenced and predominating relationships between psychotherapist burnout and work demands (J. Lee et al., 2011; M. Lee et al., 2020; Lim et al., 2010; McCormack et al., 2018; Rupert et al., 2015; Yang & Hayes, 2020). However, it is highlighted that it would be risky to imply this presents equal opportunity, much less equal responsibility, in terms of whether burnout is best remediated by psychotherapists or employing organisations. A significant body of evidence would converge in supporting that, without intervention or assistance, individuals experiencing either burnout or psychological distress are increasingly likely to experience diminished cognitive function and resources. Further, these impacts are likely to reduce any affected individual's ability to accurately evaluate or respond to stressors independently. These assertions are supported by prominent cognitive theories of psychological disorder (Beck & Haigh, 2014), theories of

occupational stress development (Dewe et al., 2012), and empirical findings considering burnout's development (Ford et al., 2014; van Dam, 2021) and cognitive impacts (Deligkaris et al., 2014). It would therefore be at best unfair (W. Johnson et al., 2012), and at worst potentially damaging (Ledingham et al., 2019), to suggest psychotherapists bear equal responsibility with their employers for addressing their workplace wellbeing. In alignment with current clinical guidance (NICE, 2022c), noting the priority for supporting workplace wellbeing lies predominantly with employing organisations over individual employees, the following suggestions are presented for both to consider.

Given the apparent prime importance of work-life balance and psychological detachment in enabling work recovery more broadly, particular attention should be paid to psychotherapists' workload, number of hours and overtime worked, decision-making or cognitive demands, and their ability to leave on time and take sufficient and restorative breaks during the day. These factors were collectively observed as most relating to reduced psychological detachment from work in a review of the general occupational literature (Sonnentag & Fritz, 2015). Other aspects of perceived work demands include technostress and telepressure, and the increased distress and intrusion enabled by being technologically connected to work outside work hours, with both increasingly considered likely to inhibit work recovery (K. Richardson, 2017; Sonnentag & Fritz, 2015). Telepressure was further directly related to burnout in psychotherapists (Kotera et al., 2021). It therefore appears important to prevent the normalisation of contact between employers and psychotherapists, and intrusive use of technology, outwith agreed working hours.

Work demands have been observed relating to other known psychological barriers to psychotherapist self-care. These include a fear of professional stigma for "not coping" with work demands, and self-stigmatising perceptions that to address individual needs in the context of high work demands experienced by themselves and peers would be "self-indulgent" or "selfish" (C. Baker & Gabriel, 2021; Walsh & Cormack, 1994). It would therefore appear important for both organisations and individual psychotherapists to foster a "culture of self-care", normalising the prioritisation of psychological wellbeing despite demands, and adopting a collectivist approach in supporting fellow practitioners to do so (Barnett & Cooper, 2009; W. Johnson et al., 2012).

In addition to recommendations above, it appears important employers consider supporting psychotherapists' autonomy in choice and enactment of in-work recovery activities and breaks, with it being observed more generally this maximises restorative benefits (Hunter & Wu, 2016; Trougakos et al., 2014). For psychotherapists themselves, again, given the apparent primacy of work recovery and cognitive awareness, it would appear particularly important to monitor for intrusive thoughts of work outside work hours as these may be early signs of an inability to psychologically detach and increased burnout risk (Leiter & Maslach, 2003; Sonnentag & Fritz, 2015).

Implications for Future Research

Evaluating the clinical recommendations described using experimental and/or longitudinal research designs, ideally also considering possible confounding variables, would be the strongest recommendation of this study, given reviewed analyses were exclusively cross-sectional and largely bivariate. This will enable more authoritative confirmation of whether self-regulation and recovery-based self-care interventions reduce rather than merely relate to burnout. Further, given the complex and reciprocal temporal relationship between acute, routine stress and the development of more chronic distress, including burnout (Ford et al., 2014; Guthier et al., 2020; Sonnentag & Frese, 2012), it will be crucially important to understand when in this process self-care offers greatest utility in remediating escalation.

A further methodological recommendation would be using multi-factorial measures of self-care in future research instead of overall measures or combined scores (for a review of extant measures see Jiang et al., 2020). Similarly, given a potential lack of face validity, the CSBQ is not recommended for measuring self-care use.

Regarding extant theory, present findings tentatively suggest a stronger relationship between psychotherapist self-care and routine or proactive maintenance of resources, than reactive responses to job demands. Of theoretical mechanisms proposed by included studies, this would most support Resiliency Theory (Greene et al., 2008; Kaplan et al., 1996), given its focal support of self-awareness and self-regulation in preventing burnout. Less support was found for theories foregrounding the roles of cognitive reappraisal (Folkman & Lazarus, 1988; Gentry & Kobasa, 1984) or social support (Prochaska & Velicer, 1997; Sarason et al., 1983). Review findings most notably align with recent integrations of JD-R theory and self-regulation literature (A. Bakker & de Vries, 2021), in turn supported by substantial findings in the wider workforce regarding the importance of work recovery (Bennett et al., 2018; Steed et al., 2021; Wendsche & Lohmann-Haislah, 2017). Given extant psychotherapist self-care and burnout research has been largely atheoretical, the model proposed by A. Bakker & de Vries (2021) appears a promising theoretical basis for future study.

Conclusion

To the author's best knowledge, this review is the first to systematically review the literature regarding psychotherapists' self-care in relation to burnout. Further, it is novel in delineating autonomous and self-initiated interventions from those contingent on potentially subconscious or invariant traits less amenable to modification or control. It therefore identifies practical, actionable methods by which individuals and organisations may consider remediating psychotherapist burnout.

Findings address a noted, though still understudied, literature gap concerning individually-focused burnout remediation interventions in psychotherapists. They further appear to support and extend prior observations in mental health staff and general occupational populations to psychotherapists. Specifically, they highlight the importance of restorative and preventative self-regulatory and self-awareness processes enabling recovery from work in addressing burnout.

It is hoped this review offers utility by highlighting potentially effective strategies, and by offering additional conceptual clarity regarding self-care. It is further hoped the work will both facilitate and expediate new avenues of research and intervention supportive of psychotherapists' occupational wellbeing, and in turn, their provision of much-needed mental health interventions in the wider population.

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Chapter 2. Empirical Project

Title Page: Empirical Project

Is psychotherapist self-care self-determined? The roles of autonomous motivation, work demands, professional stigma, high standards, and self-sacrifice.

[RUNNING TITLE – BARRIERS TO PSYCHOTHERAPIST SELF-CARE]

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- The informed consent of participants was obtained prior to participation.
- Permission to reproduce material, or clinical trial registration was not required for the completion of this systematic review.
- The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

[NOTE: Both this title page and the following chapter have been prepared in accordance with author submission guidance for The Journal of Clinical Psychology. Adjustments were made regarding placement of tables/figures and word count, with respect to thesis submission requirements. Author submission guidelines are included in full in **Appendix A**]

Empirical Project Abstract

Background: Self-care is an ethical and professional imperative for psychotherapists, likely to support wellbeing and professional efficacy. However, several factors have been identified in the literature which potentially inhibit psychotherapist self-care. These included those dependent on the work context, including work demands and possible professional stigma regarding self-care. They may also be inhibited by maladaptive patterns of cognition and behaviour, prevalently demonstrated in psychotherapists, including pursuing unrelenting performance standards and self-sacrifice. However, findings in the health and positive psychology literature suggest a potential role for autonomous motivation, as conceptualised within Self-Determination Theory, in facilitating psychotherapist self-care.

Methods: This cross-sectional study surveyed psychotherapists ($N=386$) via Qualtrics, capturing their self-care behaviours in multiple domains, autonomous motivation towards self-care, objective and subjective work demands, perceived sources of professional stigma, and internal drives towards high standards and self-sacrifice. Bivariate correlations, hierarchical regression, and canonical correlation analyses were used to identify the combined and unique contributions of all variables to self-care, and to explore how the most seemingly important variables collectively relate to self-care domains.

Results: Findings indicated that distinct barriers differentially impacted distinct domains of self-care. The strongest relationship observed was that between daily balance and perceived work demands. More generally, self-care in the personal domain related negatively to perceived work demands, and professional self-care, mostly the seeking of support in the workplace, related negatively with perceived structural (workplace) stigma. Relatively autonomous motivation appeared to facilitate self-care, though largely in the absence of other perceived workplace barriers.

Conclusions: Psychotherapists' perceptions of their workplace, in terms of work demands and threats of experiencing stigma or negative consequences if acknowledging a need for self-care in the workplace, represent the most significant potential barriers to their enacting self-care. Addressing these perceptions through collective organisational normalisation and discussion of self-care, and supporting psychotherapists' choice and autonomy in enacting self-care, particularly to maintain a good work-life balance, both appear important and potentially useful practical strategies for individual psychotherapists and their employers to adopt in shared support of the collective psychotherapist workforce.

Keywords: Psychotherapists, Self-Care, Relative Autonomy, Stigma, High Standards, Work Demands.

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Introduction

While the term is used substantially and inconsistently throughout the wider literature (Godfrey et al., 2011; Jiang et al., 2020), in psychotherapists, self-care can be defined as autonomously, consciously and purposefully engaging in one or many broad cognitive and behavioural strategies, applied throughout personal and professional domains, to promote holistic wellbeing (Colman et al., 2016; Dorociak, Rupert, Bryant, et al., 2017; J. J. Lee et al., 2020; Santana & Fouad, 2017). It is a practice strongly emphasised within relevant professional and ethical standards, which require psychotherapists to routinely monitor and attend to their wellbeing to maintain professional efficacy (APA, 2021; Canadian Psychological Association, 2017; European Association for Psychotherapy, 2018; Health & Care Professions Council, 2016). Further, it is frequently recommended that routine and proactive enactment of self-care in psychotherapists prevents their routine experiences of occupational stress cumulatively progressing into more chronic distress (e.g. burnout), thus preventing increased associated risks to themselves and their patients (APA, 2008; Baker, 2003; Bamonti et al., 2014; Barnett et al., 2007; Bohall & Bautista, 2017; M. Collins & Cassill, 2021; Norcross & VandenBos, 2018a; E. Wise & Barnett, 2016). This recommendation is consistent with all empirically-supported theories of general occupational stress development (Dewe et al., 2012; Kelloway et al., 2008), longitudinal meta-analytic findings in the wider workforce (Ford et al., 2014; Guthrie et al., 2020; Sonnentag & Frese, 2012), and emerging empirical findings in qualified and trainee psychotherapists (Colman et al., 2016; Rupert & Dorociak, 2019; Zahniser et al., 2017). A significant literature correspondingly describes psychotherapist self-care as an ethical imperative, throughout training and qualified life (Bamonti et al., 2014; Barnett et al., 2007; Bohall & Bautista, 2017; M. Collins & Cassill, 2021; Maranzan et al., 2018; Miller, 2021; Norcross & VandenBos, 2018b; Pope & Vasquez, 2016; E. Wise et al., 2012; E. Wise & Barnett, 2016).

The strategies represented by extant conceptualisations of psychotherapist self-care further demonstrate significant apparent organisational value. In contrast to the inattention and disengagement associated with burnout (Pope & Vasquez, 2016; Rupert et al., 2015), self-care encapsulates several strategies representing pro-active awareness and work engagement (Dorociak, Rupert, Bryant, et al., 2017; J. J. Lee et al., 2020). Self-care also encapsulates many strategies linked to work recovery (Sonnentag & Fritz, 2007), meta-analytically associated in general occupational literature with improved employee wellbeing and performance, and reduced exhaustion/fatigue, including some longitudinal support (Bennett et al., 2018; Steed et al., 2021; Wendsche & Lohmann-Haislah, 2017). Specifically, self-care encapsulates several strategies based on work detachment (Sonnentag, 2012; Sonnentag & Fritz, 2007, 2015; Wendsche & Lohmann-Haislah, 2017), mostly by promoting physical/mental boundaries from work, and being sufficiently engaged in other pursuits, including relaxation/recreational activities (Dorociak, Rupert, Bryant, et al., 2017; J. J. Lee et al., 2020; Santana & Fouad, 2017; Sonnentag & Fritz, 2007; Steed et al., 2021). Self-care finally also encapsulates using breaks and holidays (Dorociak, Rupert, Bryant, et al., 2017; J. J. Lee et al., 2020; Santana & Fouad, 2017), a necessary precursor given detachment and relaxation strategies require absence from work.

In summary, self-care strategies likely support wellbeing and performance in the general workforce, with emerging evidence indicating the same in psychotherapists. Further, while evidence regarding self-care's direct impacts on more chronic psychotherapist distress (burnout) remains in its infancy, as evidenced by the preceding systematic review, there is some evidence suggesting its benefits even at this late stage. Regardless, extant professional standards of conduct highlight self-care behaviours represent optimal and ethical psychotherapeutic practice. It is therefore crucial for both psychotherapists and their employers to understand how to optimally facilitate self-care.

Barriers to Psychotherapist Self-Care

The facilitation of psychotherapist self-care is particularly important given common acknowledgement that psychotherapists struggle to address or even disregard their own self-care (E. Baker, 2003a; Bober & Regehr, 2006; Bohall & Bautista, 2017; Sherman, 1996; Welfel, 2015), even when aware their distress or impairment will likely adversely impact patient care (Guy et al., 1989; Pope et al., 1987; Sherman, 1996). Notably, 59% of psychologists surveyed by Pope et al. (1987) reported working when too distressed to be effective. An identical percentage of psychotherapists surveyed by Bearse et al. (2013), and 58.2% of mental health professionals (mostly psychologists, 69.2%) surveyed by J. L. Edwards & Crisp (2017), reported they would have previously benefitted from professional help for mental distress but did not seek it when required. Similarly, 83% of clinical psychologists surveyed by Darongkamas et al. (1994), meeting criteria suggesting significant distress, were not accessing appropriate therapeutic support, with only 35% reporting even having considered doing so. Several possible barriers to psychotherapist self-care have been identified in the literature to explain these findings, categorised as broadly occupational or personal factors (O'Connor, 2001).

Occupational Barriers to Psychotherapist Self-Care

First considering occupational barriers, within a notably limited literature (Morris, 2018), work demands appear the most prominent among psychotherapists. Qualitative observations in UK Clinical Psychologists and Counsellors noted time and work pressures as the biggest self-care barriers (C. Baker & Gabriel, 2021; Brownlee, 2016; Morris, 2018), an observation reflected in empirical findings regarding trainee psychotherapists (70.6%), who cited a lack of time due to other commitments as the greatest barrier to personal self-care (El-Ghoroury et al., 2012). Similarly, 49% of qualified UK Clinical Psychologists sampled by Walsh & Cormack (1994), reported time pressures prevented them seeking support at work.

Observations that work demands prevent psychotherapist self-care aligns with findings regarding psychotherapist burnout. Given burnout is commonly conceptualised as arising via successive experiences of individuals' resources being overwhelmed/depleted by work demands (Demerouti et al., 2001; Hobfoll & Freedy, 1993), factors significantly relating to burnout likely represent similar threats to using self-care. Notably, work demands, including workload, role overload and pressure, are the most commonly implicated work-based factors significantly positively relating to burnout in psychotherapists (M. Lee et al., 2020; McCormack et al., 2018; Westwood et

al., 2017; Yang & Hayes, 2020) and the wider mental health workforce (O'Connor et al., 2018). Further, it appears perceived workload impacts burnout more significantly in psychotherapists than objective measures of demand (e.g. hours worked) (M. Lee et al., 2020). This highlights the importance of also considering intrapersonal factors regarding self-care.

Personal Barriers to Psychotherapist Self-Care

Stigma. The most frequently identified intrapersonal factors inhibiting psychotherapist self-care involve perceptions of possible stigma, mostly relating to being a mental health professional disclosing psychological distress. This includes fear of being stigmatised by others, with qualitative evidence indicating psychotherapists fear unfavourable comparison with “perfect copers” colleagues if admitting they require support, consequently finding such expressions of need psychologically threatening (Walsh & Cormack, 1994). Related fears of perceived stigma and shame particularly around “being a client”, perceived as a “failure”, or anticipating negative judgement, have also been reported as preventing psychotherapists seeking support or disclosing/addressing personal difficulties, particularly at work (Cain, 2000; Charlemagne-Odle et al., 2014; Ledingham et al., 2019; Walsh & Cormack, 1994).

These qualitative findings appear supported empirically, as far back as findings from Deutsch (1985), who reported 34% of psychotherapists they surveyed had not sought personal therapy when needed, citing fear of exposure and concerns regarding professional censure as significant contributors. More recently, a survey of 678 UK-based clinical psychologists (Tay et al., 2018) reported while two-thirds of participants had experienced mental health problems, more than half experienced reluctance to share this with colleagues/superiors. In those who never disclosed, cited barriers included fear of being judged negatively (71.7%), and possible negative career impacts (67.4%). In those who never sought help, over a third cited the same factors as barriers. Similar results were found by J. L. Edwards & Crisp (2017) in Australian mental health professionals ($N=98$, 69.2% psychologists), where over two-thirds reported experiencing feared personal or professional consequences of disclosing or seeking support for mental health issues. Concerns included what co-workers may think, say or do, other people they knew finding out, and not wishing mental health problems to be recorded in their medical history (J. L. Edwards & Crisp, 2017). Related findings were also observed in UK and US clinical psychology trainees, where social stigma reduced positive attitudes toward seeking personal therapy (Digiuni et al., 2013), and in a sample ($N=387$) of mostly clinical and counselling psychology graduate students (66.4%), in which “worry about what could happen” was the third-highest endorsed barrier to self-care (32.6%) (El-Ghoroury et al., 2012).

Alongside concerns regarding stigmatisation by others, self-stigmatisation also appears a barrier to self-care in psychotherapists. Qualitative findings indicate psychotherapists perceive admitting to needing support, while working in a professional context typified by high workloads and demand, as “self-indulgent” or “selfish” (C. Baker & Gabriel, 2021; Walsh & Cormack, 1994). Similarly, in a qualitative study involving 55 mental health professionals ($n=28$ psychotherapists) (Ledingham

et al., 2019), participants commonly reported distress sufficient to warrant the need for remediation (i.e. burnout), whether previously experienced or merely hypothesised, would prompt self-stigmatising feelings of blame and related perceptions of weakness, failure and incompetence, further resulting in their avoiding acknowledging any need to address distress. These observations again appear empirically supported by findings from J. L. Edwards & Crisp (2017), who noted over two thirds of participants cited feelings of embarrassment or shame (69.8%) as barriers to help-seeking. Similarly, El-Ghoroury et al. (2012), noted participants cited anticipated shame, guilt or embarrassment (29.6%) as barriers to self-care. More recent qualitative findings suggest this occurred during the COVID-19 pandemic, with some psychotherapists more reluctant to acknowledge distress or seek support, believing they “should” know how to cope given their profession (British Psychological Society, 2020c).

Developmental or Predisposing Individual Differences. In addition to barriers regarding stigma more contingent on psychotherapists’ professional context, it is suggested internalised predispositions based on developmental history and past experiences should also be considered regarding psychotherapist distress and self-care (O’Connor, 2001). More recent findings preliminarily support this assertion, noting a significant potential role for psychotherapists’ personal beliefs, cognitive biases, and consequent coping responses in the prevention or development of burnout (Ledingham et al., 2019; Rupert et al., 2015; Simionato & Simpson, 2018). Related research in psychotherapists has correspondingly examined the role of early maladaptive schemas (Young et al., 2003).

In an international sample of qualified clinical and counselling psychologists ($N=443$), early maladaptive schemas most commonly reported were unrelenting standards (e.g. perfectionism, rigid self-expectations regarding performance and responsibility) and self-sacrifice (heightened sensitivity to others’ needs, tendency to prioritise others at one’s own expense) (Simpson et al., 2019). Further, significant proportions of respondents demonstrated levels indicative of clinical significance or pathology (unrelenting standards 60% approx., self-sacrifice 50% approx.)(Simpson et al., 2019). These schemas were also the highest endorsed in cross-cultural samples of clinical and counselling psychology trainees (Kaeding et al., 2017; Saddichha et al., 2012). Further, a recent systematic review in the wider healthcare workforce confirmed the presence of both schemas most prominent in psychotherapists, and more so than in other mental health professionals (e.g. psychiatrists) (Kempf et al., 2021). These findings align with frequent qualitative observations noting beliefs relating to the need to maintain unrelenting standards, or preferences for self-sacrifice, appear to represent barriers to self-care or addressing burnout in mental health staff, including psychotherapists (Brownlee, 2016; Charlemagne-Odle et al., 2014; Hammond et al., 2018; Ledingham et al., 2019). The presence of these internal drives may be further evidenced by an observed disparity regarding perceived pressure to attend work in NHS England clinical psychologists and psychotherapists. Of all surveyed in 2019 ($N=5180$), 94.2% reported putting themselves under pressure to attend work when unwell, compared to just 11.8% reporting pressure from co-workers ($N=5168$) and 14.7% from managers ($N=5168$)(NHS England, 2019).

The Possible Role of Motivation in Promoting Self-Care

Alongside possible barriers to psychotherapists self-care, recent findings and the wider occupational health psychology literature both advocate considering facilitators of self-care engagement, especially motivational factors (Jiang et al., 2020; Otto et al., 2019; Sonnentag et al., 2017). As self-care can refer to any strategies promoting health and wellbeing (Rupert & Dorociak, 2019), health psychology research exploring motivation for related behaviours offers potentially valuable insights.

Considering the promotion of motivation towards multiple health-promoting behaviours, interventions derived from Self-Determination Theory (SDT) have demonstrated efficacy in diverse populations and contexts (Teixeira et al., 2020). SDT differentiates motivation along a continuum ranging from controlled to autonomous (Ryan & Deci, 2017), with health behaviour change appearing more effective and lasting when patients experience more autonomous and internally-derived, or “self-determined”, motivation (Ng et al., 2012; Ntoumanis et al., 2021). Self-determined motivation has also been demonstrated to enhance behavioural precursors, including positive attitudes and perceptions of ability, both in turn increasing intention towards target behaviours (Hagger & Chatzisarantis, 2009). The opposite of autonomous motivation is controlled motivation (externally-derived). As an explanatory example, someone autonomously motivated to lose weight may exercise or diet because they internally value or have identified health benefits of doing so. In contrast, someone experiencing controlled forms of motivation may act only to avoid negative consequences, either from external sources (e.g. criticism from others for being overweight), or internal sources (e.g. guilt and shame for not exercising/dieting).

In terms of the relative impacts of distinct motivators in health-behaviour change, controlled forms of motivation have at best demonstrated only briefly increasing behavioural engagement, though accompanied by feelings of anxiety and dissatisfaction (Ng et al., 2012). At worst, controlled forms of motivation have been negatively related to mental/physical health and engagement in health-promoting behaviours (Ng et al., 2012). Some support for SDT’s relevance for psychotherapist’s self-care, an inherently autonomous process (Colman et al., 2016; Dorociak, Rupert, Bryant, et al., 2017; J. J. Lee et al., 2020; Santana & Fouad, 2017), is found in literature considering burnout in psychotherapists (J. Lee et al., 2011; Steel et al., 2015; Yang & Hayes, 2020) and mental health staff more widely (O’Connor et al., 2018), where promotion of staff autonomy and control is commonly recommended as protective against burnout. Similarly, findings from the wider organisational literature indicate autonomous choice and preference support self-care activities’ restorative benefits (Hunter & Wu, 2016; Isoard-Gautheur et al., 2019; Trougakos et al., 2014). These findings appear to collectively support assertions that helping professionals’ self-care inherently needs to be self-determined (Butler et al., 2019) for maximum benefit.

Given autonomy’s potential importance for psychotherapists self-care and wellbeing, it is concerning psychotherapists appear subject to several prominent external sources of controlled

motivation to self-care. These firstly include the significant weight of professional guidance and literature reviewed previously, strongly advocating their ethical and professional imperative to self-care. Secondly, the predominant public response to COVID-19, both in the literature and by numerous professional bodies, including those relevant to psychotherapists, was to further and more strongly emphasise individual practitioners' obligation to self-care (Academy of Medical Royal Colleges, 2020; APA, 2020; BMA, 2020a; BPS, 2020a, 2020b, 2020c; Chenneville & Schwartz-Mette, 2020; HCPC, 2020; NHS Education for Scotland, 2020; Norcross & Phillips, 2020; Rokach & Boulazreg, 2020; Royal College of Nursing, 2020). Also, as previously discussed, psychotherapists apparently experience controlled forms of behavioural motivation via perceived potential stigma for acknowledging their own distress. This arises through both external (e.g. employers, professional peers) and internal perceived threats (feelings of guilt and shame) (Cain, 2000; Charlemagne-Odle et al., 2014; Deutsch, 1985; J. L. Edwards & Crisp, 2017; El-Ghoroury et al., 2012; Ledingham et al., 2019; Tay et al., 2018; Walsh & Cormack, 1994). Further, any internally-derived autonomous motivation to self-care in psychotherapists is likely competing with directly opposing, prevalently-endorsed, maladaptive internalised drives to meet unrelenting performance standards, or self-sacrifice (Brownlee, 2016; Charlemagne-Odle et al., 2014; Hammond et al., 2018; Kaeding et al., 2017; Ledingham et al., 2019; Saddichha et al., 2012; Simpson et al., 2019), especially in the context of increased work demands (C. Baker & Gabriel, 2021; Walsh & Cormack, 1994). In summary, psychotherapists appear far likelier to experience controlled forms of motivation regarding self-care, the opposite of what SDT findings suggest as optimal for facilitating autonomous health-promoting behaviour (Ng et al., 2012; Ntoumanis et al., 2021; Ryan & Deci, 2017).

Summary of Literature Findings

Considering all literature previously reviewed, psychotherapists seemingly underuse much needed self-care, experiencing several barriers to its enactment. These include work demands, perceived threats of role-related stigma, and the likely presence of competing maladaptive drives towards self-sacrifice and unrelenting performance standards. Psychotherapists are simultaneously highly likely to be experiencing the opposite of what relevant motivational theory indicates as optimal to enable overcoming these barriers and enacting self-care.

Current Research Aims and Hypotheses:

Considering the above, this study proposes to: (1) explore and quantify the impact of identified barriers to self-care in psychotherapists; (2) explore the potential role of motivation from an SDT perspective in supporting or undermining psychological practitioners' self-care; (3) explore which of these factors, alone or in combination may particularly inhibit or promote psychotherapist self-care. Despite the exploratory nature of this study, based on literature reviewed, the following directional hypotheses are proposed: (H1) Work demands (objective and perceived), professional stigma, high standards and self-sacrifice will negatively relate to self-care; (H2) Autonomous motivation will positively relate to self-care.

Materials and Methods:

Design

A non-experimental, cross-sectional study design was employed. Self-report data was collected via online survey utilising the Qualtrics® platform. This methodology was favoured, relative to more robust longitudinal or non-self-report approaches, to minimise intrusion and demand for NHS participants during the COVID-19 pandemic.

Inclusion and Exclusion Criteria

Participants were required to:

- A) Be currently employed:
 - (i) by a UK-based health or social care organisation (statutory or third sector).
 - (ii) as a psychological practitioner in a regulated qualified or pre-qualification role (*including Doctors of Clinical Psychology, Counselling Psychologists, otherwise professionally qualified or accredited Psychotherapists, Psychological Wellbeing Practitioners, Primary Care Mental Health Workers, Assistant Psychologists, Trainee Clinical Psychologists, or trainee/qualified Clinical Associates in Applied Psychology*).
 - (iii) in one or some combination of the above roles for at least the past two months (with no significant recent absences if new in their current role).
- B) Be able to communicate in English
- C) Be 18 or over
- D) Have normal vision (or corrected to normal vision with the use of visual aids e.g. glasses, contact lenses).

Criteria regarding work sector were based on observations psychotherapists working in private or independent practice experience distinct additional work demands compared to those employed in public/third sector services, especially reduced access to peer and professional support structures (Finan et al., 2022; Hammond et al., 2018; J. Lee et al., 2011). Given this is likely to disproportionately impact the utilisation of certain categories of self-care (Dorociak, Rupert, Bryant, et al., 2017), including private psychotherapists was thought to risk potentially confounding dependent variable results. Language requirements were due to no proposed study measures having received validation in other languages. The final criteria respectively ensure ability to provide informed consent and to complete the electronic survey respectively.

Statistical Power and Sample Size Planning

As the research was novel in comparing selected variables, existing research could not inform a priori power analysis. Proposed effect sizes, deemed a minimum denoting likely practical significance in clinical psychological or social science data, were therefore first identified in the literature (Barker et al., 2016; Ferguson, 2009), ranging from $f^2=.04$ to .15 (J. Cohen, 1988).

Commonly-cited heuristic approaches (Green, 1991) for calculating multiple regression sample size likely result in under-powered samples, limiting statistical inference (M. Bakker et al., 2016; Maxwell, 2000). The use of G*Power software (Erdfelder et al., 2009) is consequently more highly recommended (Dattalo, 2018).

Sample sizes were calculated based on seeking to detect a significant increase in the proportion of self-care variance explained (R^2) following inclusion of one or more variables into a hierarchical regression model (Tabachnick & Fidell, 2019). Considering intended variables and measures, maximum numbers of IVs to be tested within each regression model step (5), and of possible covariates at the final entry step (17), were identified. To observe a significant R^2 change under these conditions, using the conventionally proposed alpha error probability of .05, and statistical power of .80 outlined by (J. Cohen, 1988, 1992), G*Power indicated a minimum sample requirement of $N=93$, to detect a medium effect size ($f^2=.15$), and a sample size of $N=314$ to detect a minimum effect size representing “practical” significance in the data ($f^2=.04$).

Survey Design

The survey was created on the Qualtrics® online platform, considering key ethical principles of valid consent, the right to withdrawal, and scientific integrity (BPS Research Board, 2017).

The survey was shared only via private anonymous link, and de-indexed from search engines. Browser cookies prevented multiple responses from individual participants (“ballot stuffing”), with participants informed prior to participation. Cookies further allowed participants to return and complete the survey in stages if required, acknowledging likely respondent time pressures. Correspondingly, a graphical progress bar was displayed showing percentage completion, supporting respondents informed use of their time (BPS Research Board, 2017). A paged design was used providing both multiple opportunities for respondents to reaffirm consent or withdraw (BPS Research Board, 2017), and multiple points of data storage (Toepoel, 2017).

Two information pages, available for download by participants (**Appendix G**), started the survey, outlining sufficient study details to ensure informed consent (e.g. research aims, privacy protections) and eligibility respectively, with explicit consent items enabling participants to confirm both (BPS, 2014).

Recognising protection against error and bias in surveys inherently requires methodological compromise (Hox et al., 2008), and given participants’ anticipated limited time/availability, minimising non-response bias was prioritised (Dillman et al., 2014b; Hox et al., 2008). As forced completion was found to increase dropout and reduce data quality in online surveys (Sischka et al., 2022), item non-response (Dillman et al., 2014b; Hox et al., 2008) was minimised instead via customised response request messaging, presented only in the event items were incomplete and

participants attempted to progress. Customised JavaScript code also highlighted incomplete/missed items.

In line with recommendations to prevent unit non-response, salient or interesting questions were placed nearest the survey start, and the most sensitive/aversive questions near the end (Dillman et al., 2014a). While this took precedence over randomisation of question blocks to minimise response-order effects (Toepoel, 2017), where measures did not indicate specified item orders, items were randomised to assist in minimising response bias and low-effort responding (Meade & Craig, 2012).

Demographic questions began the survey given their importance in organisational research, and because doing so maximises their completion without detriment to subsequent survey item completion (Teclaw et al., 2012). This also afforded the ability to identify and adjust for demographic factors potentially relating to unit or item non-response during later analysis (Dillman et al., 2014b; Hox et al., 2008). Items relating to self-care were captured next given their likely salience for participants based on recruitment/study information provided. It was felt participants being prompted to consider intrapersonal factors prior to discussing workplace challenges could inadvertently contextualise workplace difficulties experienced in terms of personal attributes (Schwarz et al., 2008; Strack et al., 1991). As reviewed literature indicated self-blame for experiencing difficulty of this kind occurs in psychotherapists (Walsh & Cormack, 1994), item order was fixed in the opposite order, progressing through work and role-related barriers (demands, stigma), before more sensitive personal (high standards, self-sacrifice) variables.

A “withdraw” button was placed on each page allowing participants to leave and have their responses deleted at any point. Whether leaving or completing the survey, all participants were provided the same info/opportunities, though on distinctly worded pages. All were thanked for their time and provided access to debriefing information, including documents outlining the study background/rationale (**Appendix H**), sources of support in the event of participant discomfort or distress (**Appendix I**), and a second opportunity to download the participant information (**Appendix G**). Participants were finally provided contact information for the research team should they have questions or wish to know the results of the study, a University contact independent of the researchers for any other enquiries, and a contact at the School of Health and Social Sciences for any possible complaints.

The final survey included 82 items across nine pages (including those for eligibility, consent and debriefing). Completion time, based on analysis by the Qualtrics® system and beta-testing, was approximately 10 minutes, indicating low participant burden (Qualtrics®, 2022). This increased to a maximum potential time of 25 minutes if reading additional study information beyond that required for informed consent.

Procedure

Ethical Approval

A study protocol (**Appendix J**) was submitted and sponsorship obtained from the University of Edinburgh College of Arts, Humanities and Social Sciences (CAHSS) Research Governance Coordinator (**Appendix K**). Ethical approval was then sought and attained from the University of Edinburgh School of Health in Social Science Review Board (**Appendix L**). The research was registered and approval obtained by the local NHS health board's Research and Development Office via the Health Research Authority's Integrated Research Application System (IRAS)(HRA, 2022)(**Appendix M**).

Participant Recruitment and Data Collection

Access was granted to all psychotherapists employed by the lead researcher's employing NHS health board ($n=108$), and all trainees on both Edinburgh and Glasgow Universities' respective Clinical Psychology Doctorate courses ($n=217$). Recognising initial recruitment may not achieve the desired sample size, recruitment contingencies were identified. Preliminary contact was made with several UK professional organisations representing psychotherapists, seeking access in principle to members. Finally, opportunities for recruitment via social media and by snowball recruitment within the researchers' professional networks were considered.

Data collection commenced on 15th November 2021. Participants were contacted via email by NHS and University administrative staff. Emails contained text inviting participation (**Appendix N**), a web link to the survey, a promotional poster (**Appendix O**), and participant information sheet (**Appendix G**). Only two reminder emails were sent to minimise intrusion and because no additional gain has been found sending more (Cho et al., 2013). As no optimal follow-up timing was indicated in the literature (Cunningham et al., 2015), reminders were sent monthly, accounting for staff absences and to permit flexibility for participants. Phased collection further enabled assessment potential nonresponse bias (Gosling & Johnson, 2010) (see later). The first reminder email was sent on 15th December 2021, with participation further promoted by members of the health board's Psychological Therapies Staff Wellbeing Steering Group. Within a month of sending the final email reminder on 18th January 2022, participant numbers ceased increasing. Preliminary data inspection showed 141 responses were returned, indicating a response rate of 43.7% from this known initial sample. However, accounting for incomplete, ineligible, and possible low-effort and outlier responses, the total of complete responses achieved would likely remain within the minimum-to-low sample size range indicated by power calculations.

Pre-approved recruitment contingencies (**Appendix L, page 233**) were therefore deployed on 15th February 2022. The survey link was shared publicly on the Research Notice Board of the official British Association for Counselling and Psychotherapy (BACP) website. Participation was also promoted within the BACP Postgraduate Research Forum. The link was also shared with the entire

membership ($N=6400$ approx.) of a private Facebook group restricted to qualified and trainee UK Clinical Psychologists. Posts on online forums and websites included the same invitation text and survey link as the original invitation emails. Finally, invitation emails were shared electronically via snowball methods amongst NHS Scotland psychotherapists within the researchers' professional networks. Acknowledging prime ethical research responsibilities to respect participants' autonomy and dignity while maximising benefit in findings (BPS, 2021), the survey was left open until participation slowed sufficient to indicate all invited to participate had been afforded sufficient time to do so, with data collection consequently concluded on 30th April 2022.

Measures Used

The final online survey included the following self-report measures. All were either free to use or used with original authors' permission.

Demographic Information. Demographic variables were limited to maximise respondent anonymity (BPS, 2021) and minimise non-response bias (Dillman et al., 2014b; Hox et al., 2008). Potentially confounding variables identified from the literature were prioritised, including gender, age, years in the profession, and qualification status (prequalified vs qualified) (Bettney, 2017; Dorociak, Rupert, & Zahniser, 2017; El-Ghoroury et al., 2012; Rupert & Kent, 2007). Additional variables captured objective work demands, including working hours, full/part-time status, percentage of working hours spent in direct client contact vs other work (e.g. research/admin/academic study), and work setting (urban/rural/mixed).

The Self-Care Assessment for Psychologists (SCAP). The SCAP is a 21-item measure assessing five self-care domains found relevant to psychotherapists' functioning and wellbeing (Dorociak, Rupert, Bryant, et al., 2017), including professional support (PS), professional development (PD), life balance (LB), daily balance (DB), and cognitive awareness (CA). Participants report frequencies they use each on a seven-point Likert scale (1 = "Never", 7 = "Always").

Developed in practicing psychotherapists ($N=422$) the SCAP demonstrates high face and content validity. Robust procedures were used for item-generation (using established conceptual frameworks), and content evaluation/modification (including expert feedback). The SCAP is further the only self-care scale structurally validated via both exploratory and confirmatory factor analysis (Jiang et al., 2020), receiving further validation in post-graduate clinical psychology trainees (Zahniser et al., 2017). Finally, the measure consistently demonstrates adequate reliability, with subscale Cronbach's alphas ranging almost exclusively between .70 and .83 (Dorociak, Rupert, Bryant, et al., 2017; Zahniser et al., 2017). In this study, reliability was good for the life balance subscale ($\alpha=.82$), acceptable for professional support ($\alpha=.76$) and cognitive awareness ($\alpha=.76$), though fell slightly into the questionable range for the daily balance ($\alpha=.70$) and professional development ($\alpha=.67$) subscales. Permission for use was provided by the lead author K. Dorociak (personal communication, 8th June 2020).

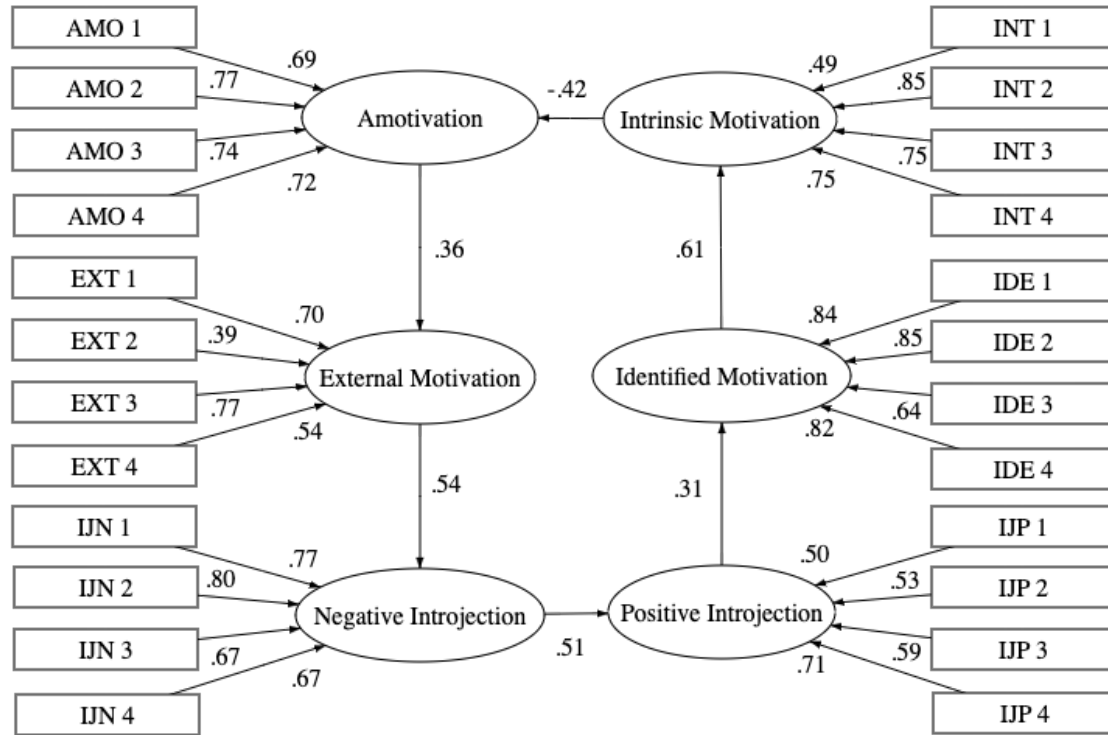
The Comprehensive Relative Autonomy Index (C-RAI). The C-RAI (Sheldon et al., 2017) was developed to confirm and capture self-determination theory's proposed relative autonomy continuum (SDT). Twenty-four items describe distinct motives for engaging with a target behaviour. Respondents rate agreement on a scale of 1 (Strongly disagree) to 5 (Strongly agree). The items form six subscales capturing distinct, increasingly autonomous forms of motivation, respectively amotivation, external motivation, negative introjection, positive introjection, identified motivation, and intrinsic motivation. A total score representing overall relative autonomy towards a target behaviour (presently self-care) is obtained, following recommendations, via an unweighted equation (i.e. intrinsic + identified + positive introjection – negative introjection – external – amotivation) (Sheldon et al., 2017). The measure also returns a mean motivation score, enabling the comparison of motivation “quantity” versus “quality” (relative autonomy).

The measure was designed specifically for adaption to new behaviours, by modifying semantically invariant item stems (e.g. “because I enjoy X”, where X is replaced by target behaviours). These stems incorporate a previously and extensively validated factor structure (Howard et al., 2017; Sheldon et al., 2017), conferring construct and content validity. Reliability was assessed in four international samples (total $N=958$) (Sheldon et al., 2017), with observed Cronbach's alpha values from .61 to .94 (mostly $>.70$) indicating acceptability. In the present study reliability was good for the identified ($\alpha=.87$) and amotivation ($\alpha=.82$) subscales, acceptable for the intrinsic ($\alpha=.79$) and negative introjection ($\alpha=.75$) subscales, though questionable for the positive introjection ($\alpha=.66$) and extrinsic ($\alpha=.68$) subscales. Permission for use was provided by the lead author K.M. Sheldon (personal communication, 24th July 2020).

As the C-RAI items created for the purposes of this survey (**Appendix P**) constitute a new measure, confirmatory factor analysis was conducted. A non-orthogonal analysis model allowed for expected inter-correlations between latent variables (Howard et al., 2020). A maximum likelihood estimation with robust (Huber-White) standard errors (MLR) was used as for ordinal scale response data with likely inter-factor correlation, this estimator likely provides greater population coverage (C. Li, 2016). The first-order six-factor structure from the original C-RAI study (Sheldon et al., 2017) was tested, demonstrating acceptable model fit ($\chi^2 = 468.1$ (237), $p<.001$; CFI=.92; RMSEA=.05, 90% CI [.04, .06]) (Brown, 2015). Factor loadings very closely approximated the original validation studies (mostly $>.7$, range .39 to .85) (Sheldon et al., 2017) (**Figure S5**). Further significant inter-factor correlations were observed in patterns predicted by SDT theory (Howard et al., 2020). Adjacent factors positively correlated, indicating proximity on the self-determination continuum, however the least/most self-determined forms of motivation (amotivation and intrinsic motivation respectively) were negatively correlated (**Figure S5**).

Figure S5.

Parameters of C-RAI Confirmatory Factor Analysis Model (Incl. Inter-Factor Correlations).



Note. Diagram based on model outlined by Sheldon et al. (2017). Arrows between latent variables represent significant ($p < .05$) bivariate correlations, with arrow direction representing progression through SDT continuum, from least (amotivation) to most (intrinsic) autonomous forms of motivation. Item labels/numbers correspond to item categories and numbers listed in **Appendix P**.

The Health and Safety Executive Management Standards Indicator Tool (HSEMS-IT). The eight-item “demands” subscale of the HSEMS-IT (Health and Safety Executive, 2020) captured perceived work demand. Respondents reported how frequently they experienced various demands using a seven-point Likert scale (1 = “Never”, 7 = “Always”). The measure arose from extensive theoretical research and widespread UK public consultation, consequently demonstrating high content and face validity (Cousins et al., 2004; MacKay et al., 2004). Its factorial validity was confirmed during development (Cousins et al., 2004) ($N=3147$) and subsequently via further large-scale confirmatory factor analyses ($N=26,382$ and $N=67,347$) in UK public-sector samples which included substantial proportions of NHS services (between 26% and 38% of respondents) (J. A. Edwards et al., 2008; J. A. Edwards & Webster, 2012). It has demonstrated good construct and concurrent validity, relating predominantly in expected fashions with psychological wellbeing, job satisfaction and performance (Brookes et al., 2013; Houdmont et al., 2013), including in healthcare staff and psychological practitioners (Kerr et al., 2009; Summers et al., 2020). Finally, the subscale demonstrated acceptable Cronbach’s alpha reliabilities of between .84 to .89 across several large-scale studies (Cousins et al., 2004; J. A. Edwards et al., 2008; J. A. Edwards & Webster, 2012; Houdmont et al., 2013), and good reliability in this study ($\alpha=.89$).

Mental Health Professional Stigma Scale (MHPSS). The MHPSS captured stigmatising beliefs and attitudes held by mental health professionals regarding occupational stress and burnout across four domains (Clough et al., 2020). Structural stigma and perceived other stigma describe respondents' anticipated reactions from general co-workers and fellow mental health professionals respectively, were they to disclose occupational stress/burnout. Self-stigma captures respondents' belief they should self-sufficiently manage personal distress, while personal stigma captures attitudes held towards other distressed mental health professionals. Participants rate agreement with items on a seven-point Likert scale (1 = "Strongly Disagree", 7 = "Strongly Agree").

The scale's theoretical basis and factorial validity were derived from an equivalent measure for medical professionals (Clough et al., 2019). Both measures' development however utilised small samples, limited expert item review, and exploratory rather than confirmatory factor analysis. However, assessment against established methodological quality guidance for measure development nonetheless indicated "very good" or "adequate" practice in constructing both scales (Mokkink, 2018; Mokkink et al., 2010). The MHPSS has further demonstrated initial convergent and divergent validity, and overall acceptable reliability across subscales (Cronbach's alpha mostly $>.77$) (Clough et al., 2020). In this study, reliability was good for the combined scale ($\alpha=.85$) and self-stigma subscale ($\alpha=.85$), and acceptable for structural stigma ($\alpha=.76$), perceived other stigma ($\alpha=.76$), and personal stigma subscales ($\alpha=.77$).

The Almost Perfect Scale-Revised (Short-form) (SAPS). Based on previous work by Slaney et al. (2001), the SAPS captures two perfectionism subscales related to potentially maladaptive high performance. Containing four items each, "standards" and "discrepancy" subscales respectively assess the presence of high performance standards, and self-critical/negative evaluations regarding meeting those standards (Rice et al., 2014). Participants rate agreement on a seven-point Likert scale (1 = "Strongly Disagree", 7 = "Strongly Agree").

The factorial validity of the original measure was confirmed in multiple exploratory and confirmatory factor analyses, with both subscale scores routinely demonstrating concurrent validity with measures of wellbeing and personality (Rice et al., 2014). The factor structure was replicated during SAPS development, and cross-culturally via subsequent confirmatory factor analysis (K. Wang et al., 2016). The SAPS also demonstrated criterion, convergent and discriminant validity during development (Rice et al., 2014), with additional criterion validity demonstrated since, relating with both self-report and physiological measures (Moroz & Dunkley, 2019; Perrone-McGovern et al., 2017; C. Richardson et al., 2014). Reported Cronbach's alpha scores for the Standards (.86 to .89) and Discrepancy (.84 to .88) SAPS subscales indicate acceptable reliability (Perrone-McGovern et al., 2017; Rice et al., 2014; C. Richardson et al., 2014). In this study reliability was good for both standards ($\alpha=.90$) and discrepancy ($\alpha=.90$) subscales.

The Revised Unmitigated Communion Scale (UCS-R). Unmitigated Communion describes focus on others while neglecting the self (Fritz & Helgeson, 1998). The unidimensional scale captures

endorsed beliefs and tendencies towards self-sacrifice using 9 items measuring agreement on a five-point Likert scale (1 = “Strongly Disagree”, 5 = “Strongly Agree”). Previously created for health contexts, the scale was revised to generalise to wider populations (Fritz & Helgeson, 1998). Relevant convergent validity includes observed positive relationships with enacted supportive behaviours (Helgeson & Fritz, 1999; Jacobs et al., 2015; Jin et al., 2010), and negative relationships with health-promoting behaviours relevant to self-care (including diet, exercise, relaxation)(Helgeson & Fritz, 1999). During development the measure demonstrated adequate Cronbach’s alpha reliability (ranging between .7 to .8) as well as high test–retest reliability (Fritz & Helgeson, 1998). The measure also demonstrated adequate reliability (Cronbach’s alpha .81) in a relevant population of helping professionals (Occupational Therapists)(Jacobs et al., 2015). Permission for use was provided by the lead author V.S. Helgeson (personal communication, 14th March 2021). In this study reliability was good ($\alpha=.81$).

Data Preparation & Analysis

All data was analysed using IBM SPSS v.24.0.0 for Mac OS, v.27.0.01 for Windows, Microsoft Excel, and R (R Core Team, 2013) software as required.

Of 454 responses attained, three participants withdrew, two having completed demographic items only, and one who completed no items. None provided feedback and no complaints were registered. Of those remaining, participants not meeting eligibility criteria ($n=8$), meeting criteria but not providing consent ($n=23$), or consenting but without answering any survey items ($n=16$), were removed. Of the remaining 404 responses, 350 participants completed the survey fully, representing a completion rate of 77.1%. This falls within one standard deviation of the average (87%, $SD=10\%$) calculated by Liu & Wronski (2018) in their review of online surveys ($N=25,080$), a figure considered relatively high by the authors. Attrition data at each survey stage is presented in **Appendix Q**.

Insufficient-Effort Responding. Insufficient effort responders were identified as removing even a small number can result in significantly reduced measurement error (Huang et al., 2012). Alongside visual data inspection, screening techniques included inspection of response times and longest consecutive identical responses (“longstring”). Both are recommended to identify rushing or disinterest (Hong et al., 2020; Meade & Craig, 2012; Niessen et al., 2016) anticipated given likely time/work-pressured respondents. As better results are reportedly obtained by deriving cut-off scores from each study’s own sample data, suggested calculations were undertaken (Niessen et al., 2016) and are outlined in **Appendix R**.

Participants were removed ($n=18$) if displaying persistently short page response times ($n=2$), longstring outliers for over half their completed measures ($n=8$), longstrings exceeding those possible for measures with reverse-scored items ($n=2$), or displaying stereotyped item response patterns (zig-zags) when assessed visually ($n=1$). The remainder met either two ($n=2$), three ($n=2$) or four ($n=1$) exclusion criteria.

Missing Data. Survey attrition (**Appendix Q**) displayed a monotone missingness pattern (R. Little & Rubin, 2019; Raghunathan, 2015), confirmed via inspection in SPSS (IBM, 2017). As commonly referenced missing data categories are unlikely to be mutually exclusive or practically verifiable, missing data is recommended to be considered existing somewhere between missing at random (MAR) and missing not at random (MNAR)(Graham, 2008; Newman, 2014). This aligns with findings identifying MNAR subtypes, including “diffuse” MNAR, wherein missingness relates to both observed and unobserved data (Gomer & Yuan, 2021).

Missing data in the remaining sample ($N=386$) was observed across 93.6% of variables, but only 9.1% of cases and 2.9% of overall values recorded. The SPSS missing value analysis module compared complete and incomplete responders across all variables. While Little’s (1988) MCAR test was not significant ($\chi^2=121.95$, $df=152$, $p=.965$), missingness correlated with multiple study variables. Further, literature review suggested it was likely missingness could relate to variables captured later in the survey where most missingness occurred. Specifically, respondents being overworked, fearful of professional stigma, or less perfectionistic/self-sacrificing, could potentially all decrease survey completion. As missingness could therefore plausibly relate to observed and unobserved data, a diffuse MNAR missingness mechanism was assumed.

Missing data was addressed by multiple imputation, as it is comparable to equivalent MAR management approaches (Enders, 2022), is recommended for simultaneous imputation of item and unit missing data when missingness is mostly monotone (Lang & Little, 2018), and has been shown to minimise bias both in MAR and MNAR conditions when including sufficient auxiliary variables (L. Collins et al., 2001; Lang & Little, 2018; Newman, 2014).

A fully conditional specification multiple imputation was conducted using IBM SPSS v.24.0.0 for Mac OS, creating five imputed datasets from which the final dataset was pooled. The imputation model included all intended analysis variables, and all demographic factors, having been identified as auxiliary variables (L. Collins et al., 2001; Enders, 2022). Sensitivity analysis later compared the multiple imputation data results to those obtained using complete case analysis.

Outliers. Outliers ($n=6$) were identified by inspecting standardised residuals and studentised deleted residuals in SPSS, with respondents flagged if exceeding ± 3 standard deviations from the mean for either (Pituch & Stevens, 2016). Leverage and influence were also assessed (Chatterjee & Hadi, 1986). No respondents were flagged as influence points, all attaining Cook’s Distance values <1 (Cook & Weisberg, 1982)(maximum = .190). Leverage was assessed in line with guidance by Huber & Ronchetti, (2009), with values greater than .2 indicating risk, and greater than .5 indicating danger to model generalisability. Three respondents attained leverage scores between .36-.39, however this was potentially because they were the only three respondents reporting neither male nor female gender (e.g. gender nonconforming, genderfluid, nonbinary, agender). Not wishing to exclude on demographic minority grounds, and as they were not otherwise flagged as outliers/influential points, these respondents remained included in analysis. No other respondents demonstrated leverage values $>.2$. Outlier inclusion was nonetheless evaluated by later sensitivity analysis.

Data Assumptions. There was independence of residuals for all regression models as assessed using the Durbin-Watson statistic (range 1.79 to 1.99). Linear relationships were confirmed between all DVs, demographic items and IVs by visual inspection of partial regression scatterplots. Linear relationships between all DVs and other variables collectively, as well as homoscedasticity, were confirmed by visually inspecting plots of studentised residuals versus unstandardised predicted values.

Very little evidence of multicollinearity was found with almost all correlation coefficients between IVs/DVs well below .70 (Tabachnick & Fidell, 2019), and no collinearity variance inflation factors (VIF) greatly exceeding 1, falling far below extant cut-offs of concern ($>2.5-10$) (Allison, 1999; Myers & Myers, 1990). The only exception was a large correlation observed ($>.70$) between age and years of relevant experience, demonstrating VIF scores up to 3.8 (approx.). Sensitivity analysis was later conducted to investigate the impact on overall findings of retaining only one of these variables.

Assessment of univariate normality was not required given the observed residual plots (Tabachnick & Fidell, 2019). However, no continuous variables displayed deviation from normality as assessed by visual inspection of histograms and Q-Q plots, and attained values for skewness and kurtosis falling well within recommended limits (max. ± 1.9 , mostly $\pm <1$) (Curran et al., 1996; Kline, 2015). Further, skewness and kurtosis were deemed highly unlikely to substantively impact findings, given the attained sample size (Field, 2018; Tabachnick & Fidell, 2019).

Statistical Analyses. Monotonous scale transformations were first conducted for all non-demographic continuous data using the percent of maximum possible (“POMP”) method (P. Cohen et al., 1999). This renders comparable results ranging from 0 to 100 for all variables, ensuring differences observed remain correctly proportioned, retaining respondents’ degree of item endorsement (Moeller, 2015). Two categorical demographic variables (gender and work setting) included three categories each. These were recoded into four binary dummy variables, coded relative to the largest subgroups, to enable inclusion in regression analyses.

To accurately indicate the relative importance of IVs regarding self-care, tests included both bivariate Pearson’s correlations between all study variables, and subsequent regression analyses to determining unique and combined contributions of IVs (Tabachnick & Fidell, 2019).

Given that IVs were hypothesised to follow a temporally and logically assumed sequence of priority, hierarchical multiple linear regression models were chosen (Petrocelli, 2019; Tabachnick & Fidell, 2019). Demographic variables and experimental IVs were categorised into blocks for entry (using the “enter” method in SPSS) into five hierarchical models for each SCAP self-care domain. Demographic variables (age, gender, years in profession, qualification status) were entered first, acting as controls (Petrocelli, 2019). Given their potential developmental or historical acquisition (Simpson et al., 2019) SAPS perfectionism and UCS-R self-sacrifice preceded all other measures.

Objective work demands (working hours, full/part-time status, percentage of hours in direct clinical contact, urban/rural/mixed work setting) preceded subjective demands (HSEMS-IT) given perception of experience is predominantly based on first acquiring said experiences. Collective work demands preceded all remaining variables as literature reviewed indicated they provide contextual influence on perceptions of professional stigma (C. Baker & Gabriel, 2021; Walsh & Cormack, 1994). Motivational variables were entered last, given their inherent theoretical conceptualisation as being influenced by all external and internal factors (Deci & Ryan, 2015).

Adjusted- R^2 values quantified the variance in DVs attributable to the combined IVs in each step of all regression models. To better evaluate population cross-validity and generalisability of findings (Pituch & Stevens, 2016), these values were calculated based on Burket's procedure (Burket, 1964), which demonstrated the least bias among available approaches relevant to the current study's design and characteristics (sample size/number of IVs) (Raju et al., 1999; Schmitt & Ployhart, 1999). Squared semipartial correlations (sr_i^2), quantifying each IV's unique contribution to DV variance, were used to determine the relative importance of individual IVs within all steps of each model (Tabachnick & Fidell, 2019). Effect sizes were interpreted in line with Cohen's (1992) recommendations. However, considering potential relevance of findings to real-world application, values deemed minimums of practical significance in social science data ($r=.20$, $R^2/sr_i^2=.04$) were also applied (Ferguson, 2009). This equated to values of .20, .30, and .50 for Pearson's r , and of .04, .13, and .26 for R^2 and sr_i^2 (Dattalo, 2008), representing small, medium and large effect sizes respectively.

Given the large number of proposed comparisons, familywise type-I error was controlled at each stage/level of inference previously described. Test families therefore included: (1) the total bivariate comparisons between DVs, demographic and all other IVs; (2) the total number of blocks tested in each hierarchical regression model; (3) all IVs included at each regression stage. The Holm-Bonferroni procedure was chosen to control familywise error, being uniformly more powerful than the Bonferroni procedure (Abdi, 2010), and able to maintain the overall error rate in a "strong" rather than "weak" sense (i.e. regardless of the amount of true/false null hypotheses observed) (Levin, 1996).

Possible moderating and mediating relationships between variables were considered based on bivariate and multivariate findings, based on criteria for identification outlined by Baron & Kenny (1986). Non-controlled exploratory analysis was finally conducted via canonical correlation, including only IVs identified as significantly individually relating to self-care, to better describe their collective relationships.

Results

Descriptive Statistics

Categorical and continuous sample characteristics are displayed respectively in **Tables E1** and **E2**. Respondents included 386 participants ranging from 23 to 65 years of age ($M=36.9$, $SD=8.9$),

identifying as female (89.4%), male (9.9%) or neither (0.8%) (gender nonconforming, genderfluid, nonbinary, or agender). On average they worked 34 hours per week ($SD=6.4$), engaging in direct clinical/patient contact 41.1% ($SD=21.9\%$) of the time, having spent 12.6 years ($SD=8.2$) in a relevant role. Most participants held relevant professional qualifications in psychotherapy (75.1%) and worked full-time (71.1%) in a mixed urban/rural geographic area (47.8%).

Table E1

Categorical Sample Characteristics

Categorical Demographic Variable	<i>n</i>	%
Gender		
<i>Female or Primarily Feminine (including transgender women)</i>	344	89.4
<i>Male or Primarily Masculine (including transgender men)</i>	38	9.9
<i>Neither male nor female (e.g. gender nonconforming, genderfluid, nonbinary, agender)</i>	3	0.8
Qualification Status		
<i>Holds professional psychotherapy qualification</i>	289	75.1
<i>Does not hold professional psychotherapy qualification</i>	96	24.9
Working Pattern		
<i>Full-time</i>	273	71.1
<i>Part-time</i>	111	28.9
Geographic Working Area		
<i>Mixed</i>	183	47.8
<i>Urban</i>	136	35.5
<i>Rural</i>	64	16.7

Table E2

Continuous Sample Characteristics

Continuous Demographic Variable	<i>M</i>	<i>SD</i>	Min.	Max.
Age	36.9	8.9	23.0	65.0
Years in a relevant role	12.6	8.2	1.0	43.0
Weekly hours worked	34.0	6.4	7.5	56.0
Percentage of direct clinical working time per week	41.1	21.9	0.0	95.0

Descriptive statistics for all dependent and independent variables are provided in **Table E3**. Respondents on average reported life balance (LB) as the most-utilised form of self-care, followed by cognitive awareness (CA), professional support (PS), professional development (PD) and daily balance (DB). They further reported experiencing comparatively higher levels of autonomous motivation on average than more controlled forms of motivation to self-care. Of variables representing known potential barriers to self-care, respondents average scores were highest for high standards, followed

by overall perfectionism, perceived work demands, self-sacrifice, discrepancy, and lastly by all forms of stigma.

Table E3

Dependent and Independent Variable Scores

Dependent Variables	<i>M</i>	<i>SD</i>	Min.	Max.
Self-Care Assessment for Psychologists (SCAP)				
<i>Professional Support</i>	68.0	14.8	23.3	100.0
<i>Professional Development</i>	55.4	14.9	6.7	93.3
<i>Life Balance</i>	76.0	14.6	7.5	100.0
<i>Daily Balance</i>	51.6	21.4	0.0	100.0
<i>Cognitive Awareness</i>	74.4	13.8	0.0	95.0
Independent Variables	<i>M</i>	<i>SD</i>	Min.	Max.
The Comprehensive Relative Autonomy Index (C-RAI)				
<i>Amotivation</i>	15.9	16.0	0.0	68.75
<i>External Motivation</i>	27.9	19.6	0.0	87.5
<i>Negative Introjection</i>	33.8	20.5	0.0	93.8
<i>Positive Introjection</i>	60.2	17.6	6.3	100.0
<i>Identified Motivation</i>	78.0	15.9	12.5	100.0
<i>Intrinsic Motivation</i>	69.9	16.1	0.0	100.0
<i>Relative Autonomy</i>	67.4	8.1	34.2	84.2
<i>Mean Motivation</i>	47.6	9.1	24.0	69.8
The Health and Safety Executive Management Standards Indicator Tool (HSEMS-IT)	56.1	18.8	0.0	100.0
Mental Health Professional Stigma Scale (MHPSS)				
<i>Perceived Structural Stigma</i>	32.6	18.1	0.0	95.83
<i>Self-Stigma</i>	26.8	22.5	0.0	94.4
<i>Perceived Other Stigma</i>	20.1	16.2	0.0	72.2
<i>Personal Stigma</i>	16.9	15.6	0.0	66.7
<i>Combined Total Scale</i>	24.1	13.0	1.39	66.7
The Almost Perfect Scale-Revised (Short-form) (SAPS)				
<i>Standards</i>	78.2	19.1	12.5	100.0
<i>Discrepancy</i>	49.5	25.7	0.0	100.0
<i>Combined Total Scale</i>	63.8	18.8	8.3	100.0
The Revised Unmitigated Communion Scale (UCS-R)	57.5	16.2	8.3	100

Note. All scores in this table represent percentage of maximum possible (POMP) scale or subscale values to facilitate comparison.

Bivariate Correlation Analysis

Correlations between self-care variables are presented in **Table E4**. Moderate to large positive intercorrelations were observed between all dependent self-care variables, apart from DB which showed mostly weak relationships with other forms of self-care.

Table E4

Bivariate Correlations Between Dependent Self-Care Variables

	1	2	3	4
Dependent Variables (SCAP)				
1. Professional Support				
2. Professional Development	.62**			
3. Life Balance	.51**	.35**		
4. Daily Balance	.13**	.21**	.25**	
5. Cognitive Awareness	.44**	.42**	.36**	.36**

* = Correlation is significant at the $p < .05$ level (two-tailed)

** = Correlation is significant at the $p < .01$ level (two-tailed)

Bold** = Correlation remained significant after correcting for family-wise type I error rate ($\alpha = .05$) using Holm-Bonferroni method.

Correlations between self-care and all demographic and experimental variables are presented in **Table E5**.

Table E5

Summarised correlations between all demographic and independent variables for all self-care outcomes.

	Self-care Domains (Dependent Variables)				
	PS	PD	LB	DB	CA
Demographic Variables					
<i>Male^a</i>	-.04	-.04	-.15**	.06	-.04
<i>Neither Gender^a</i>	-.08	-.02	.04	.11*	.04
<i>Age</i>	.07	.01	-.07	-.06	-.02
<i>Years in a Relevant Role</i>	.08	.04	-.04	-.16**	-.02
<i>Being Unqualified^b</i>	-.03	-.04	-.07	.03	-.02
Independent Variables					
Intrapersonal					
<i>High Standards</i>	.12*	.12*	-.05	-.13*	.15**
<i>Discrepancy/Concerns</i>	-.19**	-.14**	-.23**	-.15**	-.15**
<i>Self-Sacrifice</i>	-.03	-.02	-.11*	-.18**	-.12*
Work Demands (Obj.)					
<i>Part-Time Working^c</i>	.03	.07	.05	-.01	.00
<i>Weekly Hours</i>	.03	.02	-.07	.03	-.07
<i>% Clinical Work Weekly</i>	-.08	-.01	-.04	-.06	-.10*
<i>Urban Work Setting^d</i>	-.07	-.08	-.01	.02	.01
<i>Rural Work Setting^d</i>	.04	.11*	.01	.02	.05
Work Demands (Perc.)					
<i>HSEMS-IT Demands</i>	-.09	-.20**	-.13*	-.48**	-.13*
Stigma					
<i>Perceived Struct. Stigma</i>	-.33**	-.25**	-.15**	-.06	-.19**
<i>Self-Stigma</i>	-.15**	-.08	-.12*	-.13*	-.20**
<i>Perceived Other Stigma</i>	-.18**	-.10*	-.08	-.04	-.16**
<i>Personal Stigma</i>	-.15**	-.09	-.09	-.03	-.07
Motivation					
<i>Relative Autonomy</i>	.25**	.19**	.32**	.33**	.33**
<i>Mean Motivation</i>	.06	.07	.10*	.16**	.10*

Key. PS = SCAP Professional Support subscale; PD = SCAP Professional Development Subscale; LB = SCAP Life Balance subscale; DB = SCAP Daily Balance Subscale; CA = SCAP Cognitive Awareness subscale; "Entry" denotes testing the significance of the variable or block of variables at the point they were entered into the regression model; "Full" denotes testing the significance of the variable or block of variables at the point by which all other variables have been entered into the regression model; Work Demands (Obj.) refers to objective measures of work demand; Work Demands (Perc.) refers to perceived work demands as measured by the HSEMS-IT.

a = Dummy variable coded from categorical gender item with 3 original categories. Comparison group = female.

b = Comparison group = holding a professional qualification to practice psychotherapy.

c = Comparison group = full time working pattern.

d = Dummy variable coded from categorical work setting item with 3 original categories. Comparison group = mixed work setting.

* = Correlation is significant at the $p < .05$ level (two-tailed)

** = Correlation is significant at the $p < .01$ level (two-tailed)

Bold** = Correlation remained significant after correcting for family-wise type I error rate ($\alpha = .05$) using Holm-Bonferroni method.

Accounting for familywise error and minimum effect sizes of practical significance, no significant relationships were observed between demographic and work-related variables. Perceived work demands negatively related to DB and PD with moderate and weak effect sizes respectively. No stigma variables correlated meaningfully with self-care, apart from perceived structural stigma, which displayed moderate and weak negative correlations with PS and PD respectively. Perfectionism and self-sacrifice did not correlate with any self-care variable, apart from discrepancy relating negatively and moderately to LB. Relative autonomy correlated positively with all forms of self-care, weakly with PS and PD, and moderately with LB, DB, and CA.

Correlations between demographic and independent variables are summarised in **Table E6**. Some weak to moderate correlations were observed where expected between demographic and work variables (e.g. working part-time correlating negatively with weekly working hours). The largest correlation was between age and years of experience ($r=.84$). No other correlations of practically meaningful size ($r>.20$) were observed.

Regarding correlations between IVs, the largest were moderate positive correlations between self-sacrifice and both perfectionism subscales. A slightly smaller though still moderate negative correlation was observed between relative autonomy and discrepancy. Weaker positive relationships were observed between perceived work demands and both perceived structural stigma and discrepancy. Self-stigma also correlated weakly and positively with discrepancy and self-sacrifice. Perceived other stigma correlated weakly and positively with discrepancy. Relative autonomy also correlated weakly and negatively with perceived work demands, self-sacrifice, and all stigma variables apart from personal stigma. Conversely, mean motivation correlated weakly and positively with self-stigma and both perfectionism subscales. Considering correlations within IVs, weak-to-moderate intercorrelations were observed between several stigma variables, and the two perfectionism subscales moderately positively correlated.

Table E6

Bivariate correlations between demographic and all tested experimental variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Demographic Variables (SCAP)																			
1. Male ^a	-																		
2. Neither Gender ^a	-.03																		
3. Age	-.03	-.10																	
4. Years in a Relevant Role	-.09	-.10	.84**																
5. Being Unqualified ^b	.01	.02	-.26**	-.24**															
Tested Experimental Variables																			
6. Part-Time Working Pattern ^c	-.10	.01	.21**	.19**	-.33**														
7. Weekly Hours	.16**	-.04	-.29**	-.23**	.23**	-.50**													
8. % Clinical Work Weekly	.01	-.10	.08	.04	-.25**	.12*	-.05												
9. Urban Work Setting ^d	.07	.00	-.14**	-.17**	.08	-.15**	.08	-.08											
10. Rural Work Setting ^d	-.05	-.04	-.01	-.04	.02	-.02	.01	.10	-.33**										
11. Perceived Work Demands ^e	-.08	-.02	.09	.17**	-.17**	.02	.01	.12*	.00	-.09									
12. Perceived Structural Stigma ^f	.02	.05	.03	.01	-.05	.01	-.08	.00	-.01	-.07	.23**								
13. Self-Stigma ^f	-.02	.06	-.17**	-.14**	.05	-.03	.10	-.06	.02	.02	.06	.15**							
14. Perceived Other Stigma ^f	-.03	.05	-.08	-.07	-.01	-.03	.02	-.06	.01	-.10*	.11*	.53**	.52**						
15. Personal Stigma ^f	-.01	.00	.01	.01	-.04	-.10*	-.05	-.05	.02	-.07	.04	.29**	.27**	.38**					
16. High Standards ^g	-.09	.02	-.20**	-.19**	.13**	-.04	.08	-.09	.03	.00	.10	-.02	.15**	.03	-.03				
17. Discrepancy/Concerns ^g	-.04	.02	-.13*	-.12*	.07	-.05	.08	-.08	-.03	.00	.26**	.12*	.26**	.22**	-.02	.40**			
18. Self-Sacrifice ^h	-.15**	.03	-.13*	-.08	.19**	-.03	.04	-.07	-.06	.07	.13**	.11*	.26**	.13*	-.01	.38**	.41**		
19. Relative Autonomy ⁱ	-.05	-.01	.05	.05	-.12*	.05	-.09	.07	-.06	.07	-.22**	-.18**	-.26**	-.22**	-.13**	-.07	-.34**	-.25**	
20. Mean Motivation ^j	.00	.06	-.18**	-.18**	.08	-.05	.13*	-.02	-.08	.10*	.00	.03	.28**	.17**	.13*	.20**	.20**	.20**	-.13*

Key. a = Dummy variable coded from categorical gender item with 3 original categories. Comparison group = female; b = Comparison group = holding a professional qualification to practice psychotherapy; c = Comparison group = full time working pattern; d = Dummy variable coded from categorical work setting item with 3 original categories. Comparison group = mixed work setting; e = Measure used was the Health and Safety Executive Management Standards Indicator Tool (HSEMS-IT); f = Measure used was the Mental Health Professional Stigma Scale (MHPSS); g = Measure used was the Almost Perfect Scale-Revised (Short-form)(SAPS); h = Measure used was the Revised Unmitigated Communion Scale (UCS-R) i = Calculated using the formula RA = (Intrinsic + Identified + Positive Introjection) – Negative Introjection – External – Amotivation; j = Calculated as a grand mean of all C-RAI motivational subscale scores, representing total motivation “quantity” (Sheldon et al., 2017).

* = Correlation is significant at the $p < .05$ level (two-tailed)

** = Correlation is significant at the $p < .01$ level (two-tailed)

Bold** = Correlation remained significant after correcting for family-wise type I error rate ($\alpha = .05$) using Holm-Bonferroni method.

Hierarchical Regression Analysis

The findings of five hierarchical regression models, with SCAP self-care domains as their respective dependent variables, are summarised in **Table E7** and presented fully in **Appendices S to W**.

Table E7

Summarised significance of independent variables at each step of hierarchical regression analyses for all self-care outcomes.

Blocks of Independent Variables (ordered by point of entry into hierarchical regression)	Self-care Domains (Dependent Variables)									
	PS		PD		LB		DB		CA	
	Entry	Full	Entry	Full	Entry	Full	Entry	Full	Entry	Full
1 Demographics	-	-	-	-	-	-	■	-	-	-
Male ^a	-	-	-	-	●	-	-	-	-	-
Neither Gender ^a	-	-	-	-	-	-	-	-	-	-
Age	-	-	-	-	-	-	●	-	-	-
Years in a Relevant Role	-	-	-	-	-	-	●	-	-	-
Being Unqualified ^b	-	-	-	-	-	-	-	-	-	-
2 Intrapersonal	■	-	■	-	■	-	■	-	■	-
High Standards	●	●	●	●	-	-	-	-	●	-
Discrepancy/Concerns	●	●	●	-	●	-	-	-	●	-
Self-Sacrifice	-	-	-	-	-	-	-	-	-	-
3 Work Demands (Obj.)	-	-	-	-	-	-	-	-	-	-
Part-Time Working ^c	-	-	-	-	-	-	-	-	-	-
Weekly Hours	-	-	-	-	-	-	-	-	-	-
% Clinical Work Weekly	-	-	-	-	-	-	-	-	-	-
Urban Work Setting ^d	-	-	-	-	-	-	-	-	-	-
Rural Work Setting ^d	-	-	-	-	-	-	-	-	-	-
4 Work Demands (Perc.)	-	-	■	-	-	-	■	-	-	-
HSEMS-IT Demands	-	-	●	-	-	-	●	●	-	-
5 Stigma	■	-	-	-	-	-	-	-	■	-
Perceived Struct. Stigma	●	●	●	●	-	-	-	-	-	-
Self-Stigma	-	-	-	-	-	-	-	-	-	-
Perceived Other Stigma	-	-	-	-	-	-	-	-	-	-
Personal Stigma	-	-	-	-	-	-	-	-	-	-
6 Motivation	■	-	-	-	■	-	■	-	■	-
Relative Autonomy	-	-	-	-	●	●	●	●	●	●
Mean Motivation	-	-	-	-	●	●	●	●	●	●

Key. PS = SCAP Professional Support subscale; PD = SCAP Professional Development Subscale; LB = SCAP Life Balance subscale; DB = SCAP Daily Balance Subscale; CA = SCAP Cognitive Awareness subscale; "Entry" denotes testing the significance of the variable or block of variables at the point they were entered into the regression model; "Full" denotes testing the significance of the variable or block of variables at the point by which all other variables have been entered into the regression model; Work Demands (Obj.) refers to objective measures of work demand; Work Demands (Perc.) refers to perceived work demands as measured by the HSEMS-IT; a = Dummy variable coded from categorical gender item with 3 original categories. Comparison group = female; b = Comparison group = holding a professional qualification to practice psychotherapy; c = Comparison group = full time working pattern; d = Dummy variable coded from categorical work setting item with 3 original categories. Comparison group = mixed work setting.

■ = Step in regression model produced a statistically significant change in self-care outcome variance explained after correcting for family-wise type I error rate ($\alpha = .05$) using Holm-Bonferroni method.

● = Individual variable significantly related to self-care outcome after correcting for family-wise type I error rate ($\alpha = .05$) using Holm-Bonferroni method.

Professional Support (PS)

This self-care domain represents respondents' use of strategies fostering interpersonal support and relationships within the workplace (e.g. avoiding workplace isolation, sharing work-related stressors or positive experiences with colleagues).

Adding intrapersonal variables at step 2 statistically significantly increased PS variance explained (R^2 increase=.08, $F(8,377)=10.92$, $p<.001$, adjusted- R^2 increase=.06), as did adding stigma variables at step 5 (R^2 increase=.10, $F(18,367)=10.93$, $p<.001$, adjusted- R^2 increase=.08). While motivational variables' inclusion at step 6 was also statistically significant (R^2 increase=.03, $F(20,365)=7.47$, $p=.001$, adjusted- R^2 increase=.03), increased variance explained was below the threshold of practical significance ($<.04$). The full final regression model was statistically significant, $R^2=.24$, $F(20,365)=5.76$, $p=.001$, adjusted- $R^2=.16$.

Of intrapersonal variables entered, only standards ($B=.19$, 95% CI [.10, .28], $p<.001$) and discrepancy ($B=-.16$, 95% CI [-.22, -.09], $p<.001$) individually significantly related to PS, displaying positive and negative relationships respectively. These relationships remained significant after including all other variables. Considering stigma, only perceived structural stigma related significantly (negatively) to PS individually ($B=-.27$, 95% CI [-.36, -.17], $p<.001$), remaining the largest and only practically meaningful ($sr_i^2>.04$) individual contributor to PS variance ($sr_i^2=.06$) in the final model.

Professional Development (PD)

This domain represents respondents' self-caring via enhancement of knowledge and skills, connection with professional organisations, work-related and community event participation, and enjoyment of professional activities.

Adding intrapersonal variables at step 2 statistically significantly increased PD variance explained (R^2 increase=.05, $F(8,377)=7.19$, $p<.001$, adjusted- R^2 increase=.02), as did adding perceived work demands at step 4 (R^2 increase=.04, $F(14,371)=15.21$, $p<.001$, adjusted- R^2 increase=.03), and including stigma variables at step 5 (R^2 increase=.04, $F(18,367)=4.46$, $p<.001$, adjusted- R^2 increase=.03). The full final regression model was statistically significant, $R^2=.17$, $F(20,365)=3.77$, $p<.001$, adjusted- $R^2=.09$.

Of intrapersonal variables entered, only standards ($B=.17$, 95% CI [.08, .26], $p<.001$) and discrepancy ($B=-.13$, 95% CI [-.19, -.06], $p<.001$) individually significantly related to PD, displaying positive and negative relationships respectively. Perceived work demands also related significantly (negatively) to PD individually ($B=-.16$, 95% CI [-.25, -.08], $p<.001$). Finally, as with PS, only perceived structural stigma related significantly (negatively) to PD individually ($B=-.19$, 95% CI [-.29, -.10], $p<.001$). Only standards ($B=.15$, 95% CI [.06, .23], $p=.001$) and perceived structural stigma ($B=-.19$, 95% CI [-.28, -.09], $p<.001$) remained significantly related to PD in the final model. No individual variable or block of variables demonstrated practically meaningful relationships with PD (adjusted- R^2 or $sr_i^2>.04$).

Life Balance (LB)

This self-care domain represents respondents' spending time with friends and family, time spent participating in comforting activities, and maintaining a sense of belonging and connection in life.

Adding intrapersonal variables at step 2 statistically significantly increased LB variance explained (R^2 increase=.06, $F(8,377)=8.65$, $p<.001$, adjusted- R^2 increase=.05), as did adding perceived work demands at step 6 (R^2 increase=.07, $F(20,365)=16.24$, $p<.001$, adjusted- R^2 increase=.06). The full final regression model was statistically significant, $R^2=.21$, $F(20,365)=4.72$, $p<.001$, adjusted- $R^2=.13$.

Discrepancy was the only intrapersonal variable significantly related to LB (negatively) ($B=-.13$, 95% CI [-.19, -.06], $p<.001$). No other variables individually related to LB in the full final regression model apart from relative autonomy ($B=.42$, 95% CI [.23, .61], $p<.001$) and mean motivation ($B=.31$, 95% CI [.15, .47], $p<.001$), both individually, significantly and positively relating to LB. However, only relative autonomy demonstrated a practically meaningful relationship ($sr^2=.04$).

Daily Balance (DB)

This self-care domain encapsulates respondents' use of strategies to balance work and relaxation (e.g. taking breaks or intentional time taken to relax during the workday, avoiding over-commitment to work responsibilities or taking on additional workload).

Adding intrapersonal variables at step 2 statistically significantly increased DB variance explained (R^2 increase=.05, $F(8,377)=6.67$, $p<.001$, adjusted- R^2 increase=.04), as did adding perceived work demands at step 4 (R^2 increase=.16, $F(14,371)=83.424$, $p<.001$, adjusted- R^2 increase=.16), and including motivation variables at step 6 (R^2 increase=.10, $F(20,365)=28.77$, $p<.001$, adjusted- R^2 increase=.10). The full final regression model was statistically significant, $R^2=.38$, $F(20,365)=11.29$, $p<.001$, adjusted- $R^2=.32$.

No intrapersonal variable significantly individually related to DB. Perceived work demands ($B=-.47$, 95% CI [-.36, -.48], $p<.001$) remained significantly negatively related to DB in the full final model, accounting for 12.8% of total DB variance (sr^2). Relative autonomy ($B=.75$, 95% CI [.50, .99], $p<.001$), and mean motivation ($B=.54$, 95% CI [.32, .75], $p<.001$) also both related individually, positively and significantly with DB, explaining 5.8% and 4.2% of total variance respectively (sr^2).

Cognitive Awareness (CA)

This domain quantifies respondents' capacity and propensity to assess and self-monitor their thoughts, feelings and reactions to others, examine their importance, maintain awareness of stress triggers, and make conscious efforts to manage workplace challenges.

Adding intrapersonal variables at step 2 statistically significantly increased CA variance explained (R^2 increase=.09, $F(8,377)=12.44$, $p<.001$, adjusted- R^2 increase=.04), as did adding stigma at step 5 (R^2 increase=.041 $F(18,367)=4.44$, $p=.002$, adjusted- R^2 increase=.03), and including motivation variables at step 6 (R^2 increase=.07, $F(20,365)=17.49$, $p<.001$, adjusted- R^2 increase=.07). The full final regression model was statistically significant, $R^2=.24$, $F(20,365)=5.60$, $p<.001$, adjusted- $R^2=.16$.

Of intrapersonal variables entered, only standards ($B=.21$, 95% CI [.13, .29], $p<.001$) and discrepancy ($B=-.11$, 95% CI [-.17, -.05], $p<.001$) individually significantly related to CA, displaying positive and negative relationships respectively. Despite their collective significance, no stigma variable individually significantly related to CA. Both relative autonomy ($B=.44$, 95% CI [.26, .62], $p<.001$) and mean motivation ($B=.27$, 95% CI [.12, .42], $p<.001$) individually significantly and positively related to CA. Despite standards remaining significantly related to CA in the full final model, only relative autonomy demonstrated a practically meaningful relationship with CA ($sr^2=.05$).

Exploratory Analysis

No potentially moderating or mediating relationships between variables were identified based on criteria outlined by Baron & Kenny (1986).

Only six variables showed significant and practically meaningful individual contributions to self-care when controlling for all other factors: standards and discrepancy, perceived work demands, perceived structural stigma, relative autonomy, and mean motivation. Further, many of these variables displayed significant if occasionally weak bivariate intercorrelations. To explore their potential collective relationship with all five similarly intercorrelated self-care domains, a canonical correlation analysis was conducted. Following recommendations (Tabachnick & Fidell, 2019), only canonical correlations and variable loadings $>.30$ were interpreted. Required assumptions for normality, linearity and homoscedasticity were met previously.

Statistically significant relationships were found between self-care and identified IVs, and are summarised in **Table E8** and **Figures E1** and **E2**. A first canonical root was significant, $\lambda=.46$, $F(30, 1502)=10.84$, $p<.001$, accounting for 36% ($r_c=.60$) of the overlapping variance. A second root was also significant, $\lambda=.73$, $F(20, 1248)=6.61$, $p<.001$, accounting for an additional 22% ($r_c=.44$) of the overlapping variance.

Table E8

Loadings and standardised canonical variate coefficients for self-care and possible facilitator / barrier variables for both canonical variates.

Variables	Canonical Variate 1		Canonical Variate 2	
	COR	COE	COR	COE
Self-Care				
Professional Support	-.34	-.02	.82	.63
Professional Development	-.40	-.12	.51	-.01
Life Balance	-.50	-.23	.43	.05
Daily Balance	-.95	-.86	-.22	-.51
Cognitive Awareness	-.47	-.02	.66	.55
Potential Facilitators/Barriers				
Relative Autonomy	-.66	-.55	.39	.28
Mean Motivation	-.28	-.38	.04	.08
Perceived Workload	.78	.65	.24	.51
Perceived Structural Stigma	.22	-.02	-.60	-.60
High Standards (Perfectionism)	.17	.14	.46	.60
Discrepancy (Perfectionism)	.34	.01	-.28	-.49

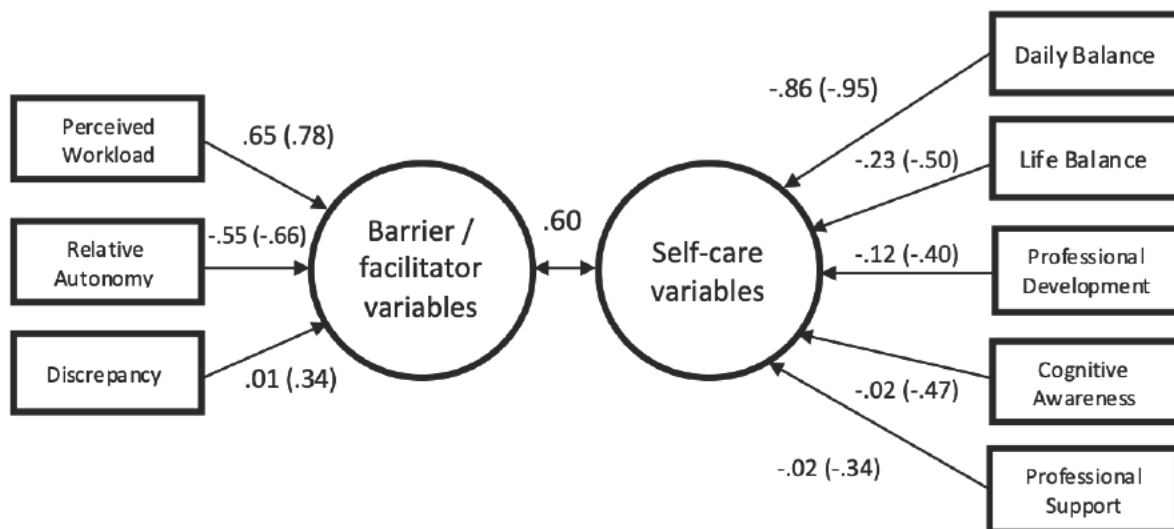
Key. COR = Loadings of each variable onto the canonical variate; COE = Standardised canonical variate coefficients; **Bold** highlights loadings >.30.

The first canonical variate included all SCAP self-care domains: daily balance (-.86), life balance (-.23), professional development (-.12), cognitive awareness (-.02) and professional support (-.02). Possible barriers/facilitators included were perceived workload (.65), relative autonomy (-.55) and discrepancy (.01). However, despite significantly loading, discrepancy's very low coefficient implied extremely limited impact. Collectively this implies that, for psychotherapists, experiencing increased perceived workload and decreased relative autonomy is significantly related to decreased self-care, most notably, daily balance and to a lesser extent life balance.

The second canonical variate included professional support (.63), cognitive awareness (.55), life balance (.05) and professional development (-.01), though the latter two variables demonstrated little impact. Possible barriers/facilitators included were perceived structural stigma (-.60), high standards (.60), and relative autonomy (.28). This implies that, for psychotherapists, experiencing the combination of reduced perceived structural stigma, high personal performance standards, and increased relative autonomy towards self-care is significantly related to increased professional support and cognitive awareness.

Figure E1.

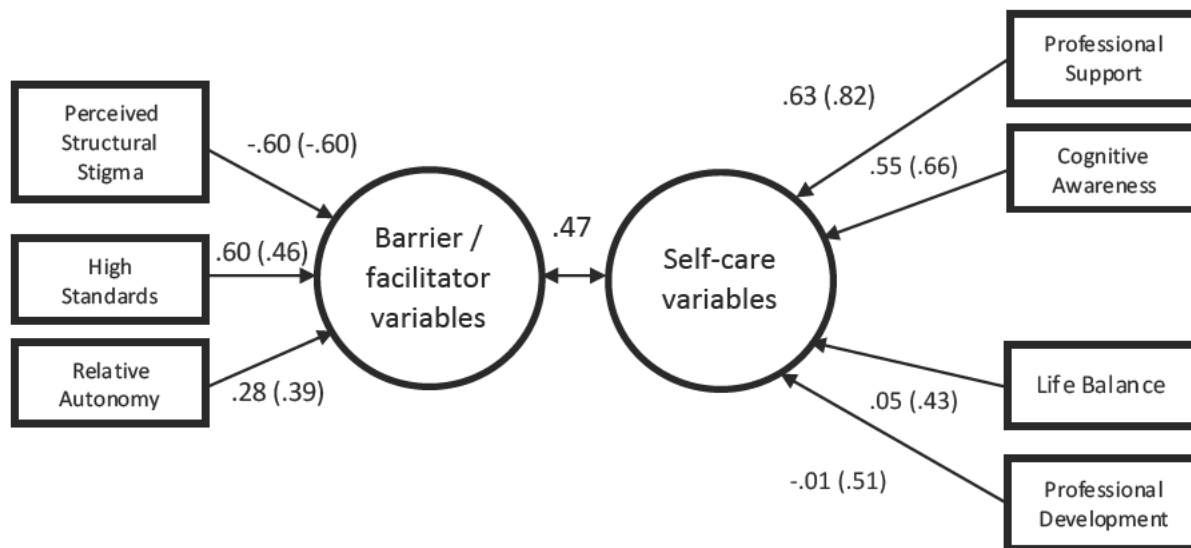
Standardised canonical correlation coefficients, loadings and canonical correlations for first significant canonical variate pair.



Note. Circles represent canonical variates. Rectangles represent individual variables. Figures outwith brackets represent standardised canonical correlation coefficients. Figure in brackets represent loadings. The figure above the bidirectional arrow in the centre represents the canonical correlation between variates. Variables with loadings <.30 are not included.

Figure E2.

Standardised canonical correlation coefficients, loadings and canonical correlations for second significant canonical variate pair.



Note. Circles represent canonical variates. Rectangles represent individual variables. Figures outwith brackets represent standardised canonical correlation coefficients. Figure in brackets represent loadings. The figure above the bidirectional arrow in the centre represents the canonical correlation between variates. Variables with loadings <.30 are not included.

Sensitivity Analysis

Non-response bias was assessed in initial NHS and university samples via wave analysis (Phillips et al., 2016), with responders to the initial invitation compared to proxy non-respondents (those doing so only after a reminder). In terms of POMP scores, analysis indicated bias averaged 0.7%, (range 0.01 to 0.19). Accounting for the number of items per scale, no variable displayed bias sufficient to meaningfully alter unit scores between waves. Nonetheless, to further assess non-response bias in the initial sample, and potential bias due to subsequent sampling methodologies used, group differences were further assessed across all IVs and DVs between initial NHS/university respondents and those obtained later via online recruitment methodologies. No significant differences were observed using Mann-Whitney U tests, accounting for unequal n .

To explore potential impacts of outlier inclusion and missing data management, relevant statistical tests were repeated using the imputed data set and complete case analysis, both with and without outliers. No notable changes to previous patterns of findings emerged in terms of significance, direction or effect size of relationships initially observed. Removal of outliers in both missing data management conditions (multiple imputation, complete case analysis) resulted in very slight (± 0.01 to 0.001) changes, mostly increases, in bivariate (r) and multivariate estimators (B , adjusted R^2). Complete case analysis resulted in slight increases in p -values ($+ .001$ approx.), and commensurate decreases in effect sizes, potentially reflective of the drop in sample size (removing $n=50$ respondents). Finally, no difference in patterns of results were observed accounting for high collinearity between age and years of relevant experience by removal of either variable from tested models. Canonical correlation results were also robust to sensitivity analyses.

Discussion

This study sought to explore, quantify and compare the impact of identified barriers and autonomous motivation as conceptualised within Self-Determination Theory to psychotherapists' self-care. It was hypothesised: (H1) identified barriers (objective and subjective work demands, stigma, high standards and self-sacrifice) would relate negatively to self-care; (H2) autonomous motivation would relate positively to self-care.

Summary and Interpretation of Study Findings

All variables in combination significantly related to each self-care domain and, in terms of explained variance, demonstrated small (9.2%, professional development), approaching-medium (12.7%, life balance), medium (15.9%, cognitive awareness; 16.4%, professional support) and large (31.8%, daily balance) effect sizes. These relationships mirror findings these five domains vary in relationship strength with various wellbeing measures in qualified and trainee psychotherapists (Elliott et al., 2021; Rupert & Dorociak, 2019; Zahniser et al., 2017).

However, despite collective significance, when controlling for demographic variables and all other IVs, only perceptions regarding the workplace (work demands, structural stigma), intrapersonal

performance factors (holding high standards and perceived discrepancy in meeting them), and autonomous motivation significantly related to self-care with practically meaningful individual effects. Canonical correlation analyses demonstrated these variables alone collectively explained 58% of combined variance across all five domains of self-care, though mostly related to daily/life balance, professional support and cognitive awareness. As not all potential barrier variables related significantly to self-care, H1 receives only mixed support.

Specifically, the only IVs found unrelated to self-care were objectively measured work demands. This may indicate observed positive relationships between objective work demands and psychotherapist burnout (McCormack et al., 2018; Rupert et al., 2015; Westwood et al., 2017) are not contingent on simultaneous reductions in self-care, given individually-focused interventions are only one possible route to managing occupational distress (NICE, 2022). It may also be that relationships between objective work demands and psychotherapist self-care are more ambiguous. For example, hours spent delivering psychotherapy has been perceived as protective or detrimental in psychotherapists based on other distinct professional and patient factors (McCormack et al., 2018; Rupert et al., 2015; Yang & Hayes, 2020). A lack of significant findings in this study relating to objective work demands may merely reflect other relevant moderating factors were not considered (e.g. caseload, patient behaviour/presentations)(McCormack et al., 2018; Rupert et al., 2015).

Greater evidence was demonstrated in this study for relationships between self-care and more subjective factors. These findings empirically support previous qualitative observations in mental health staff, including psychotherapists, reporting internal perceptions and cognitions, influenced via past experiences (Brownlee, 2016; Simpson et al., 2019), present particular barriers to psychotherapists' self-care (Ledingham et al., 2019) and their occupational wellbeing (Rupert et al., 2015). Some may consequently infer that the focal responsibility for increasing self-care uptake lies with psychotherapists themselves. However, locating responsibility for distress remediation within individual psychotherapists has already been implicated to maintain cognitive biases relating to professional competence, responsibility and fears of professional stigmatisation, observed to prevent self-care uptake (C. Baker & Gabriel, 2021; Ledingham et al., 2019; Walsh & Cormack, 1994). Further, substantial evidence from multiple fields indicates that as individuals cumulatively experience general/occupational stressors, they are correspondingly less able to effectively respond themselves (Beck & Haigh, 2014; Deligkaris et al., 2014; Dewe et al., 2012; Ford et al., 2014; van Dam, 2021). It would therefore be at best unfair (W. Johnson et al., 2012), and at worst potentially damaging (Ledingham et al., 2019), to not equally emphasise the role and responsibility of relational and systemic factors in inhibiting psychotherapists' self-care (Morris, 2018), especially given the work environment's likely significant impacts on wellbeing more generally (Grawitch et al., 2015; J. Lee et al., 2011; M. Lee et al., 2020; Lim et al., 2010; McCormack et al., 2018; Moss, 2020; Rupert et al., 2015; Yang & Hayes, 2020). Further, in this study the strongest relationships with self-care were observed for perceptual factors most directly related to work contexts (perceived work demands, structural stigma).

The work environment's likely influence on self-care is reflected in the fact the strongest and most consistent negative relationship in this study, both bivariate ($r = -.48$) and multivariately (strongest canonical variate coefficient observed, 12.8% unique DB variance explained), appeared between perceived work demands and daily balance, supporting H1. This observed relationship empirically supports qualitative findings that a common response to occupational distress, incurred via difficulty in meeting perceived work demands, is to expend additional effort and reduce daily balance (e.g. working overtime, skipping breaks, prioritising work). These responses are observed both in the general workforce (A. Bakker & de Vries, 2021; Demerouti et al., 2014; van Dam, 2021), and in qualitative studies of mental health professionals, including psychologists (Ledingham et al., 2019). The primacy of this relationship among all IVs also mirrors meta-analytic findings regarding psychotherapist burnout, in which subjective or perceived work pressures or stressors appeared more strongly and consistently positively related to burnout than objectively-measured demands (M. Lee et al., 2020). Findings finally align with qualitative research in NHS psychotherapists, in which self-care was reportedly inhibited by perceived organisational pressures regarding efficiency and targets, and co-worker attitudes/narratives appearing to prioritise work over self-care (Morris, 2018).

The workplace's influence via organisational and team culture is further reflected in significant if comparatively weaker (moderate to small bivariate relationships, small contributions to self-care variance) relationships observed presently between perceived structural stigma and professional self-care domains. Again, these findings provide only limited support for H1, given only perceived structural stigma, and not stigma regarding the self or others, related to self-care. This however reflects quantitative findings demonstrating anticipated stigma from others as the greater concern among clinical psychologists (Tay et al., 2018), and both qualitative and quantitative findings that disclosing psychological distress to workplace colleagues is perceived as threatening for psychotherapists, predominantly due to fears of anticipated reactions, censure and potential career impacts (Cain, 2000; Charlemagne-Odle et al., 2014; J. L. Edwards & Crisp, 2017; Ledingham et al., 2019; Walsh & Cormack, 1994). Considering perceived threat, the weaker relationships in this study between stigma and professional development than professional support may reflect that psychotherapists perceive it as less potentially stigmatising to engage in routine, expected professional development (Berdondini & Elton, 2020) than to acknowledge requiring professional support (Walsh & Cormack, 1994).

Considering variables less explicitly related to work contexts, there was mixed to little support that high standards, discrepancy or self-sacrifice influenced self-care, providing very limited support for H1. Bivariate relationships observed were not practically significant, apart from a weak negative relationship between life balance and discrepancy. Further, none of these variables demonstrated practically significant unique contributions to self-care variance explained. Nonetheless, the presence of high standards did significantly contribute to the second canonical covariate, relating mostly to professional support and cognitive awareness. This comparative potential importance of high standards aligns with quantitative findings in qualified and trainee psychotherapists demonstrating the unrelenting standards schema is more universally and highly endorsed, and to a

greater extent of pathology, than that of self-sacrifice (Kaeding et al., 2017; Saddichha et al., 2012; Simpson et al., 2019). Interestingly, in the current study, high standards inconsistently though mostly positively related to self-care, while the perception of failing to meet those standards (discrepancy) exclusively related negatively to self-care. The latter observation aligns with the previously-discussed likelihood of self-care being a reduced priority when perceived work demands, and hence internalised performance standards, are not being met (A. Bakker & de Vries, 2021; Demerouti et al., 2014; Ledingham et al., 2019; van Dam, 2021). It also aligns with observations that striving for high standards is not universally maladaptive, potentially reflecting adaptive aspects of conscientiousness, whereas perceived discrepancy in meeting standards more consistently indicates maladaptive perfectionism (Rice et al., 2014; Stricker et al., 2019). The importance of this perceptual context is reflected in the present canonical correlation findings where high standards related positively to self-care only in the presence of reduced perceived structural stigma and when experiencing some relative autonomy regarding self-care. This supports qualitative observations that psychotherapist self-care is less likely to occur in rigid, limiting, target-based occupational contexts wherein team cultures normalise high standards of expected workload, correspondingly stigmatising self-care (Morris, 2018; Walsh & Cormack, 1994). Findings further reflect that the role of high standards in promoting adaptive or maladaptive behaviour in psychotherapists remains unclear, mirroring ongoing literature debate (Blasberg et al., 2016).

In addition to observed relationships between potential barriers and psychotherapist self-care, the present study also identified a potential facilitator in autonomous motivation, conceptualised within Self-Determination Theory. Though mean motivation largely did not appear related to self-care, significant positive bivariate relationships were observed between relative autonomy and all self-care domains. Relationships demonstrated moderate effect sizes for life balance, daily balance and cognitive awareness, though only weak relationships with professional self-care domains, notably weakest and likely not of practical significance for professional development. Similarly, controlling for all other IVs, relative autonomy demonstrated small but likely practically significant unique contributions to explained variance only for life balance (4.2%), cognitive awareness (5%), and daily balance (5.8%), all displaying positive relationships. Mean motivation itself appeared only to meaningfully contribute positively to variance in daily balance (4.2%).

While these findings do not fully support H2, based on varying relationships across self-care domains, they support assertions in the wider occupational health literature that motivational factors are worthy of consideration in facilitating self-care (Jiang et al., 2020; Otto et al., 2019; Sonnentag et al., 2017). They further extend findings from the wider literature to the issue of psychotherapist self-care, supporting the importance of relative autonomy in health behaviour change (Hagger & Chatzisarantis, 2009; Ng et al., 2012; Ntoumanis et al., 2021; Teixeira et al., 2020). Notably, autonomous motivation related most strongly to self-care domains theoretically more within the personal domain (cognitive awareness, life/daily balance) than professional (professional support/development) (Dorociak, Rupert, Bryant, et al., 2017). Relative autonomy towards self-care

therefore, perhaps unsurprisingly, appears most impactful for self-care strategies where individual autonomy is most relevant and least impeded, demonstrated further in present canonical correlation findings, wherein relative autonomy positively related to self-care only when perceived work demands and structural stigma were correspondingly reduced.

The above demonstrates that, while relative motivation is likely of relevance to facilitating psychotherapist self-care, its influence appears contingent on contextual workplace barriers. As the cross-sectional nature of this study limits causal inference, it could equally be argued that reduced perceptual workplace barriers support psychotherapists' relative autonomy and hence self-care, or that reducing perceptual barriers is contingent on psychotherapists first being sufficiently autonomously motivated. Qualitative findings would however support the former interpretation. Despite internally valuing self-care and being aware of its need, psychotherapists demonstrated struggling to enact self-care expressly due to perceived workplace threats/barriers (C. Baker & Gabriel, 2021; Ledingham et al., 2019; Morris, 2018; Walsh & Cormack, 1994). These qualitative findings are further supported by core SDT principles and evidence asserting that anticipating perceived costs/punishment increases feelings of external-regulation towards related behaviours considered, in turn undermining relative autonomy and consequently the behaviours (Ng et al., 2012; Ntoumanis et al., 2021; Ryan & Deci, 2017). It therefore appears more likely motivation is contingent on perceived workplace barriers than vice versa.

In summary, mixed-to-limited support was found for H1, with H2 largely though not entirely supported, due to varying relationships between barrier and motivational variables and distinct self-care domains. Findings however collectively demonstrate this variation is likely related to and therefore perhaps contingent on related workplace factors. Specifically, personal domains of self-care (daily/life balance) appear potentially most impeded by perceived work demands, whereas professional self-care (professional support/development) appears potentially more strongly impeded by perceived workplace stigma. Similarly, relative autonomy towards self-care appears more likely to facilitate personal than profession self-care strategies.

Clinical Implications

Reviewed findings indicate several intervention targets of potential clinical importance. Regardless of causal direction, literature previously reviewed including the preceding systematic review would demonstrate reducing perceptions of structural stigma and work demands, and enhancing self-care and related autonomous motivation, are likely to be beneficial for psychotherapists and those they support in multiple regards (J. L. Edwards & Crisp, 2017; Elliott et al., 2021; Ledingham et al., 2019; M. Lee et al., 2020; Morris, 2018; Rupert & Dorociak, 2019; Tay et al., 2018; Walsh & Cormack, 1994; Zahniser et al., 2017). Further, relationships presently observed between variables indicate meeting these aims may be simultaneously addressed.

For example, as evidenced by the preceding systematic review, the greatest amount and quality of evidence supports psychotherapists' daily balance relates negatively with burnout.

Similarly yet conversely, a systematic review by M. Lee et al. (2020) observed perceived work demands strongly and consistently positively related to burnout in psychotherapists. These findings are therefore linked by the strongest relationship observed in the current study, that of daily balance negatively relating to perceived work demands. These findings collectively suggest that, whether perceived work demands reduce daily balance or vice versa, psychotherapist burnout is likely to reduce whether decreasing the former or increasing the latter.

Considering first how to reduce perceived work demands, it is worth first recalling these include time pressures, having to work fast/intensively, dropping certain tasks (including taking breaks), and experiencing conflicting demands (Health and Safety Executive, 2020). These collectively and notably conceptually overlap with a lack of job control/autonomy (A. Bakker et al., 2014; A. Bakker & Demerouti, 2017; Maslach et al., 2001). Strategies proposed to counteract such deficits in a recent systematic review of general occupational literature include supporting employee opportunities for choice and input, avoiding externally controlling employees (e.g. by rewards/sanctions), and proactively monitoring work pressures (Slomp et al., 2021). Longitudinal findings further emphasise benefits via engaging employees collaboratively on agreed demand remediation strategies or job/role restructuring (Bond & Bunce, 2001; Dollard et al., 2008; Härtinen et al., 2007). Given optimal implementation is contingent on each particular workforce's needs (Jones & Fletcher, 2004; Slomp et al., 2021), key considerations for psychotherapists would appear to include emphasising each individual's value, and acknowledging the complex nature and role of psychotherapy, especially within more-task oriented, target-driven systems (Morris, 2018).

Considering how to increase daily balance self-care, literature suggests it is likely best facilitated by workplace cultures that normalise rather than stigmatise taking breaks, leaving on time and boundary setting regarding additional workload/responsibilities, as opposed to normalising, or worse venerating, continually working harder at any cost (Ledingham et al., 2019; Morris, 2018; Walsh & Cormack, 1994). This aligns with recommendations for increasing collective responsibility for assuring psychotherapists' wellbeing and functioning (W. Johnson et al., 2012), promoting a "culture of self-care" (Barnett & Cooper, 2009). Suggested practical steps in doing so can be broadly categorised as: (1) increasing awareness of warning signs of distress/impairment and self-care's importance (e.g. via training/education); (2) enhanced normalisation via increased mutual support and disclosure (e.g. peer support groups, modelling and discussion of own self-care by educators/supervisors/peers) (Barnett & Cooper, 2009; Miller, 2021; Smith & Moss, 2009; Thériault, 2015). In considering both, it is worth remembering relative autonomy appears potentially facilitative of daily balance, and that this autonomy is likely undermined by external regulation (Ryan & Deci, 2017) such as didactic approaches to increasing awareness, especially if such learning is mandated (Barnett & Cooper, 2009; Thériault, 2015). It is therefore more strongly recommended daily balance self-care be facilitated by normalising distress and self-care via increased staff contact and disclosure, serving to foster mutually-supportive workplace cultures (Morris, 2018).

Finally, the strategies outlined above regarding perceived work demands and daily balance are collectively likely, based on qualitative evidence, to also undermine perceived deficits in competence and associated threats from structural professional stigma (Cain, 2000; Charlemagne-Odle et al., 2014; J. L. Edwards & Crisp, 2017; Ledingham et al., 2019; Walsh & Cormack, 1994). They are therefore likely to also enhance other forms of self-care, particularly professional support and cognitive awareness.

Study Limitations

The reviewed findings and recommendations must be considered with respect to this study's limitations. Firstly, considering methodology, it is possible SCAP results were impacted by the context of COVID-19 restrictions in place during some of the data collection period, given it included items referencing social activities (e.g. "I spend time with family or friends") (Dorociak, Rupert, Bryant, et al., 2017). More broadly, using non-probabilistic sampling and survey approaches, particularly when studying stress-related variables, potentially induces self-selection bias (Alarie & Lupien, 2021). Self-report measures also may not accurately reflect enacted behaviour (Dang et al., 2020). This is particularly salient to this study, as literature reviewed indicates the maintenance of a competent practitioner self-concept is a likely and significant internal drive in psychotherapists (Ledingham et al., 2019; Simpson et al., 2019; Walsh & Cormack, 1994), and self-care is a noted professional ethical imperative (Barnett et al., 2007). Therefore, as initial respondents included those from the author's employing health board and current training course, this could have increased associated vulnerabilities of self-report measures to self-representation and social desirability bias, with self-care potentially viewed as a normative, desirable behaviour (Brenner & DeLamater, 2016). However, some confidence in findings can be restored in this respect given this study's participants demonstrated proportional and equivalent endorsement of each self-care domain closely aligning with those of comparable studies using randomised sampling or participants more isolated from their respondents (Elliott, 2021; Zahniser et al., 2017). Further, analyses evidenced no significant differences in responses from sources in which the author was more likely to be known/unknown to participants, and anonymity was strenuously emphasised in both study and survey design.

The prioritisation of participant anonymity, necessitated by primarily seeking to recruit from within the researcher's home health board and trainee cohort on the grounds of enhanced access, itself came at additional and notable potential cost to the generalisability of findings. Attention is therefore drawn to the need to weigh and consider the following limitations and potential mitigating factors if interpreting and generalising the present study's findings to other staff populations. Considering the breadth of roles potentially responsible for the delivery of psychotherapy, and that such differences likely impact relevant experiences of occupational stress/wellbeing (Y. Lee et al., 2019; O'Connor et al., 2018; Paris & Hoge, 2010), greater confidence in the generalisability of findings could have been attained by this study capturing and reporting further demographic and professional factors. Based on their observed relevance to an expanding and diversifying psychotherapist workforce, these factors could have included as a priority participants' therapeutic specialty, patient group predominantly treated, professional subgroup (e.g. clinical or counselling psychologist), and

ethnocultural background (APA, 2018; Orlinsky, 2022; Rupert et al., 2015; The British Psychological Society, 2019). Some confidence in the generalisability of the present study's findings can nonetheless be found by considering the sources from which most responses were obtained. As these included psychotherapeutic staff across an entire Scottish NHS health board, two full university cohorts of clinical psychology trainees, and a large and diverse private social media group in which only verified UK clinical psychologists were members, it is likely respondents encapsulate a wide range of practice regarding therapeutic modalities used and patient group specialisms. Further, as these sources appear to have returned the greatest proportions of participants, while professional subgroups were not captured, it is highly likely the vast majority of respondents in the present study were trainee or qualified clinical psychologists. It was further hoped that the control and demographic variables that were captured by this study can confer significant generalisability by serving as proxies encapsulating wider core variations occurring between all participants regardless of role or specialism (e.g. percentage of time spent in clinical practice vs admin/research, years of experience).

Further considering variables not captured, another limitation of the present study is that no measure of mental wellbeing or occupational stress (e.g. burnout) was included. Doing so could potentially have provided greater empirical insight into the emerging relationship between occupational distress and self-care, whether autonomous motivation or examined self-care barriers mediate/moderate this relationship, and whether any identified self-care barrier/facilitator variables are themselves related to occupational distress. The inclusion of such variables was however weighed against several factors during the study design phase and prior to data collection. As measures of occupational distress could potentially function in this context both or either as an additional control or dependent variable, the first consideration was the additional statistical and analytical complexity introduced by their potential inclusion, and also the increase in required sample size. Secondly, qualitative feedback was obtained from prospective participants prior to study design, to ensure the practical clinical utility of the research, and to ensure a high response rate. This included feedback obtained from each team/specialism in the initial NHS health board psychological services and university trainee samples. The feedback universally stated potential respondents were "very weary" of responding to research quantifying the scale of occupational distress and burnout, and were instead more keen that research explore potential remediation strategies, or "roadblocks" to their implementation, either at individual or organisational levels. While it was consequently decided this study would instead focus on the potential barriers and facilitators of psychotherapist self-care, given their comparative lack of literature attention, not capturing participants' occupational distress limits confidence that the present study's findings are robust to its potential impacts. Nonetheless, it remains highly likely the findings of the present study are based on responses from participants experiencing varied states of mental wellbeing, if only given the widely-reported high likelihood of trainee and qualified psychotherapists experiencing occupational or more generalised mental distress (Cushway, 1992; Cushway & Tyler, 1994; Darongkamas et al., 1994; Deutsch, 1985; El-Ghoroury et al., 2012; Gilroy et al., 2002; Guy et al., 1989; Hughes et al., 2016; Pope & Tabachnick, 1994; Simionato & Simpson, 2018; Tay et al., 2018).

Finally, regarding theoretical considerations, the use of the SAPS and UCS-R rather than equivalent schema measures (Young, 2022) undermined comparability with extant literature (Simpson et al., 2019), and risks blurring conceptual distinctions between traits which may be variously adaptive or maladaptive (Rice et al., 2014; Stricker et al., 2019), and “trait-like” schemas more expressly defined as maladaptive (Young et al., 2003). This may explain non-significant findings related to these variables in the present study.

Future Research Recommendations:

Considering the collected findings and limitations of this study, future research would likely benefit from considering the following.

Regarding methodology, future research should consider using additional measures of objective work demand and psychotherapists’ professional characteristics (e.g. caseload, patient groups/presentations/behaviours, therapeutic specialism/training/role). These are likely to offer greater clarity and insight regarding potentially differential relationships between psychotherapists’ professional contexts and their self-care and wellbeing (McCormack et al., 2018; Rupert et al., 2015). Similarly, given motivational variables’ possible role in psychotherapist self-care, using specific rather than combined indices of SDT motivation would offer greater depth of insight, and potentially capture important regulation-specific effects (Howard et al., 2020).

Considering areas of future exploration, given the importance of perceived work demands in influencing daily balance self-care, and the importance of both for psychotherapist wellbeing, future research could consider potential perceptual mediators influencing how psychotherapists experience their work (Rupert et al., 2015). Specifically, if seeking to address perceived work demands, given they are inherently judged relative to subjective internalised individual standards (Bowling & Kirkendall, 2012), further consideration of the source and nature of these standards appears warranted. This is especially the case given potential methodological and theoretical limitations of the present study, preventing inference or distinction between adaptive and maladaptive performance standards. Further, value in such exploration is highlighted by the apparent shared role of related negative perceptions, especially regarding reduced performance/personal accomplishment, in both the development of burnout and prevention of self-care (Ledingham et al., 2019; Schaufeli et al., 2009). Exploration and identification of relevant shared perceptions and possible remediation factors could therefore be doubly beneficial.

Considering other perceptual factors not explored presently, those related to self-compassion, particularly as it relates to workload and professional competence, appear worthy of exploration. Descriptive findings showed daily balance self-care, permitting oneself breaks, relaxation and saying no to additional demands, was the least utilised self-care strategy in the present study. This aligns with qualitative literature indicating psychotherapists can often feel undeserving of self-care (Brownlee, 2016), especially relative to their patients (Hammond et al., 2018), and that it

would consequently be selfish/self-indulgent to consider self-care, especially in the context of high work demands (C. Baker & Gabriel, 2021; Walsh & Cormack, 1994). Correspondingly, significant proportions of the current sample endorsed motivators for self-care explicitly relating to perceived self-worth/competence, with 47.4% of respondents agreeing or strongly agreeing they were motivated to self-care to avoid “feeling bad” about themselves, and 32.6% motivated to self-care to prove to themselves they were “capable”. The above collectively supports assertions self-compassion is likely crucial for psychotherapists’ self-care (Colman et al., 2016; Morris, 2018).

This study’s findings regarding the likely influence of perceptual workplace factors on self-care align with most major occupational stress development theories, which commonly implicate the role of staff’s perceptions/appraisals regarding work in moderating stress outcomes (Dewe et al., 2012). In addition to these theories however, future examination of psychotherapist self-care and wellbeing could benefit from utilising the Self-Determination Theory framework, or by incorporating its core concepts within existing occupational theories (Dreison, White, et al., 2018). SDT conceptualises wellbeing and motivation in terms of meeting three basic psychological needs for competence, relatedness and autonomy. These overlap significantly with identified risks to self-care in this study, including perceived threats to competence (via increased perceived work demands), perceived disconnection from co-workers (via perceived structural stigma), and conversely, the likely importance of supporting psychotherapists autonomy and control as previously discussed (J. Lee et al., 2011; McCormack et al., 2018; Yang & Hayes, 2020). SDT-based interventions promoting autonomy satisfaction in the general workforce have demonstrated mostly favourable effects (Slomp et al., 2021), and are further likely to address other needs for competence and relatedness threatened by self-care barriers identified in this review (Ryan & Deci, 2017). These interventions may therefore be worthy of evaluation in psychotherapists.

Conclusion

To the author’s best knowledge, this study is the first to empirically compare identified barriers to psychotherapist self-care. Findings identified specific barriers are related differentially to distinct self-care strategies, with perceived work demands particularly negatively relating to strategies promoting work-life balance, and perceived workplace stigma particularly negatively relating to the seeking of support in the workplace. Findings therefore collectively implicate the role of perceptions regarding work as important for addressing psychotherapist self-care, with suggestions noted for how these may best be addressed practically and explored in future research. This study was further the first to consider psychotherapists’ self-care as analogous to health-behaviour change interventions, and hence consider the potential facilitative role of autonomous motivation. In doing so, findings have extended those in the wider motivational and health psychology literature to psychotherapists’ self-care, potentially supporting the applicability of a wide range of extant interventions. The present study finally also addressed a noted research gap (Yang & Hayes, 2020) by identifying two candidate targets for future burnout interventions in psychotherapists, namely the reduction of perceived workload demands and the promotion of daily

balance self-care. It is hoped the above findings can promote future research, particularly regarding workplace and individual interventions to support psychotherapists' self-care, to in turn maintain their wellbeing, and the crucial services they provide.

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Appendix A: Author Submission Guidelines for the Journal of Clinical Psychology.

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- Abstract structured (objective(s)/methods/results/conclusion)
- Up to six keywords;
- Main body:
 1. regular section formatted as introduction, materials & methods, results, discussion, conclusion
 2. In Session (invitation only) formatted as introduction, Case Illustration (including separate sections on Presenting Problem & Client Description, Case Formulation, Course of Treatment, Outcome and Prognosis), Clinical Practices and Summary, and Selected References & Recommended Readings

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Article Type	Description	Abstract / Structure	Other Requirements
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Comprehensive Reviews	critical reviews of the literature, including systematic reviews and meta-analyses	Yes, unstructured	None
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Appendix B: Systematic Review Protocol as Uploaded to PROSPERO.

Citation

Alistair Merrick, Mark Hoelterhoff, Anita Lenyk. Are staff-initiated autonomous self-care interventions effective in reducing burnout in psychotherapists?. PROSPERO 2022 CRD42022329243 Available from: https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42022329243

Review question

- What evidence exists to support the effectiveness of staff-initiated autonomous self-care interventions in reducing burnout in psychotherapists?
- Which of these interventions appear most effective in reducing burnout in this staff population?
- What is the quality of research conducted to date in this area and what improvements / gaps can be identified for future research?

Searches

Search restrictions & inclusions:

The start of the search period covered will be set as 01/01/1980. This is because no validated outcome measures for burnout were published prior to 1981. Following the initial search and identification of relevant sources, authors of eligible studies or otherwise identified as having an established research interest in the topic area shall be contacted to seek inclusion of any unpublished studies. The full search shall then be re-run shortly prior to completion of the review to check for any additional/missed sources, in line with good practice. The end date of the search frame will therefore be the date of this final literature search. No search restrictions shall be placed on the grounds of language.

Databases Searched:

The following electronic bibliographic databases shall be searched - EMBASE, MEDLINE, APA PsycINFO, Scopus, ASSIA, CINAHL, ProQuest Dissertations and Theses, and Cochrane Library.

Types of study to be included

The review will include empirical quantitative studies only, including both experimental and observational study designs. Studies will not be limited based on context, provided the study participants encapsulate the intended target population.

Any non-English language publications will be removed at this stage in order to be able to quantify the potential bias attributable their removal (Pieper & Puljak, 2021). This is on the grounds the research team are unlikely to have the time or ability to sufficiently translate resources in all possible languages in which potential articles may be published in the time-frame allocated to the review completion.

Pieper, D., & Puljak, L. (2021). Language restrictions in systematic reviews should not be imposed in the search strategy but in the eligibility criteria if necessary. *Journal of Clinical Epidemiology*, 132, 146–147. <https://doi.org/10.1016/J.JCLINEPI.2020.12.027>

Condition or domain being studied

Burnout, as assessed using measures evidenced as demonstrating at least tentative validity for the intended population of study by Shoman et al. (2021) (see "Main Outcomes").

Shoman, Y., Marca, S. C., Bianchi, R., Godderis, L., Van Der Molen, H. F., & Guseva Canu, I. (2021). Psychometric properties of burnout measures: a systematic review. *Epidemiology and Psychiatric Sciences*, 30. <https://doi.org/10.1017/S2045796020001134>

Participants/population

Inclusion:

Qualified or pre-qualification psychotherapists (those trained/training in e.g. clinical/counselling psychology or psychotherapy) for whom the central task in their role is delivering psychological therapeutic interventions to promote mental health.

Exclusion:

(1) Those trained as psychotherapists working in a predominantly academic, administrative, educational or management role, implying significantly less likelihood of routinely delivering psychological interventions.

(2) Staff for whom the delivery of psychological interventions to promote mental health (as opposed to e.g. educational attainment, independent living, sporting performance) was not the substantive or primary function of the role (*e.g. School / College / Educational Counsellors or Psychologists, Sports Psychologists, Genetic Counsellors, Rehabilitation or Vocational Rehabilitation Counsellors*).

(3) Mixed sample populations including non-psychotherapists (e.g. doctors, administrative staff).

[Note - While other professionals (e.g. social workers, psychiatrists) may deliver psychological therapy/interventions, the proportion of working hours spent doing so varies more significantly within the profession and especially internationally (e.g. school counsellors, social workers and psychiatrists in the UK vs. the USA). These professions will therefore not be included in search terms. However, sample populations will be evaluated and studies included if it is clear that the substantive function of participant's roles is delivering psychological therapy interventions to support mental health]

Intervention(s), exposure(s)

Inclusion:

- Any intervention, activity or strategy, either cognitive or behavioural in nature, which is or could reasonably:

(a) Be autonomously initiated and conducted individually (e.g. mindfulness, relaxation).

(b) Involve others at the request of the initiating individual, with a certainty of likely availability (e.g. accessing informal or ad-hoc support from known available peers, co-workers, family, friends).

Exclusion:

- Any intervention, activity or strategy, either cognitive or behavioural in nature, which could not reasonably be autonomously initiated and conducted individually, due to requiring agreement or co-ordination at a team, departmental, management, or organisational level (e.g. staff training, group wellbeing interventions, additional sessions of line management or supervision).

- Any factor not representative of an actionable cognitive or behavioural intervention, activity or strategy. This particularly includes factors such as:

(1) Those measured at a trait level (e.g. optimism/pessimism, self-efficacy, trait mindfulness)

- (2) Those representing persistent individual differences (e.g. age, gender, past experiences of trauma)
- (3) Those out-with individual's control, especially work or demographic variables (e.g. supervisor's delivery style, hours worked, patient characteristics, gender, past experiences of trauma)
- (4) Other individual differences (e.g. personality traits)
- (5) Subjective evaluative stances (e.g. attributional styles, attitudes, values, beliefs, perceived satisfaction with aspects of workplace or home environment).

Comparator(s)/control

Based on early scoping studies, it is likely most studies will be observational rather than experimental in nature. To prevent limiting the scope of the review, and in recognition of the likely emerging state of the extant literature, studies will be included with or without comparator/control groups or interventions.

Main outcome(s)

Articles will be included if the outcome of burnout was captured using one of the following five outcomes measures for which at least some evidence of psychometric validity exists in mental health professionals (Shoman et al., 2021):

- 1) The Maslach Burnout Inventory (MBI)
- 2) The Copenhagen Burnout Inventory (CBI)
- 3) The Oldenburg Burnout Inventory (OBI)
- 4) The Burnout Measure (BM)
- 5) The Psychologists Burnout Inventory (PBI)

Changes in burnout scores will be used to assess the impact of interventions/exposures.

Studies examining constructs related to burnout (e.g. compassion fatigue, work stress) without explicitly identifying burnout as an outcome related to the intervention will not be included.

Shoman, Y., Marca, S. C., Bianchi, R., Godderis, L., Van Der Molen, H. F., & Guseva Canu, I. (2021). Psychometric properties of burnout measures: a systematic review. *Epidemiology and Psychiatric Sciences*, 30. <https://doi.org/10.1017/S2045796020001134>

Measures of effect

Measures of effect will be assessed based on study design, and will potentially include pre-post intervention changes in burnout scores, as well as cross-sectional observations resulting in measures of correlation as effect size.

Additional outcome(s)

None

Data extraction (selection and coding)

Two independent reviewers will conduct study selection and data extraction using the Covidence systematic review management service (<https://www.covidence.org/>). Both reviewers will first retrieve and screen titles and abstracts of studies, before screening the full text of studies deemed relevant to assess their eligibility for inclusion in the review. Reviewers will initially be blinded to each other's decisions. Disagreement regarding screening or inclusion decisions amongst reviewers will initially be sought to be resolved via discussion. If disagreement persists, a third reviewer will be consulted, and if agreement cannot be reached, a simple majority (2 out of 3) will decide the outcome.

Extracted data will be based on relevant fields indicated in Cochrane Template Data collection forms deemed pertinent to included studies. Variables captured will include (at minimum):

Researcher Variables - Name of data extractors, date of data extraction.

Study Variables - Eligibility status (included, excluded), exclusion criteria, Study Title/Identifier (authors, year of study), geographical location of sample(s), study design, sample size, recruitment and sampling methodology, professional title/background of participants, burnout measure used, intervention or exposure variables and measures used, relationships identified between exposure/intervention factors and burnout, any additional variables required for study quality and risk of bias assessment.

Study authors may be contacted by the review team in the event required data is unavailable from the study text.

Risk of bias (quality) assessment

Given an identified likelihood of studies predominantly utilising non-randomised observational designs, and that a lack of consensus exists regarding guidance for assessing such studies' risk of bias (Mueller et al., 2018), multiple risk of bias tools tailored to specific designs may be required (Farrah et al., 2019, Quigley et al., 2019). Pending the characteristics of studies identified, available risk of bias tools will be considered (e.g. <https://osf.io/dmrq6/>), with items combined if required to create a tool suitable for the needs of this review. Any such tool would aim to assess to the fullest extent possible, the domains of confounding, selection, information, and reporting bias (in line with Cochrane guidance - <https://training.cochrane.org/handbook/current/chapter-25>).

Farrah, K., Young, K., Tunis, M. C., & Zhao, L. (2019). Risk of bias tools in systematic reviews of health interventions: an analysis of PROSPERO-registered protocols. <https://doi.org/10.1186/S13643-019-1172-8/FIGURES/1>

Mueller, M., D'Addario, M., Egger, M., Cevallos, M., Dekkers, O., Mugglin, C., & Scott, P. (2018). Methods to systematically review and meta-analyse observational studies: A systematic scoping review of recommendations. <https://doi.org/10.1186/s12874-018-0495-9>

Quigley, J. M., Thompson, J. C., Halfpenny, N. J., & Scott, D. A. (2019). Critical appraisal of nonrandomized studies—A review of recommended and commonly used tools. <https://doi.org/10.1111/JEP.12889>

Strategy for data synthesis

A narrative synthesis will be conducted detailing included studies in terms of sample population characteristics, study design, study quality/risk of bias, intervention type and content, and the significance, effect size and direction of any statistical relationships between variables of interest and the outcome of burnout.

Literature review in preparation of this protocol and review indicated a high likelihood of variation in self-care intervention and variables examined. We consequently anticipate significant clinical heterogeneity based on study design and measures used, indicating limited scope for conducting meta-analysis.

Analysis of subgroups or subsets

Subgroup analysis will be considered pending the identification of sufficient subsets of studies based on design (experimental vs non-experimental), measures used, category of self-care strategies (e.g. mindfulness activities, accessing peer support), or population (trainee vs qualified psychotherapists). These factors are considered for subgroup analysis on the basis they would help clarify which staff may benefit most from which type of interventions, and/or better assess any possible methodological effects underlying findings. The analytic approach adopted would therefore most likely utilise tests of interaction between groups.

Contact details for further information

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Organisational affiliation of the review

University of Edinburgh
<https://www.ed.ac.uk/>

Review team members and their organisational affiliations

Mr Alistair Merrick. University of Edinburgh
Dr Mark Hoelterhoff. University of Edinburgh
Ms Anita Lenyk.

Type and method of review

Narrative synthesis, Systematic review

Anticipated or actual start date

06 May 2022

Anticipated completion date [1 change]

15 August 2022

Funding sources/sponsors

None.

Conflicts of interest

Language

English

Country

Scotland

Stage of review

Review Ongoing

Subject index terms status

Subject indexing assigned by CRD

Subject index terms

Burnout, Professional; Health Personnel; Humans; Psychotherapists; Self Care

Date of registration in PROSPERO

06 May 2022

Date of first submission

06 May 2022

Stage of review at time of this submission [2 changes]

Stage	Started	Completed
Preliminary searches	Yes	Yes
Piloting of the study selection process	Yes	Yes
Formal screening of search results against eligibility criteria	Yes	Yes
Data extraction	Yes	Yes
Risk of bias (quality) assessment	Yes	Yes
Data analysis	Yes	Yes

Revision note

Record was updated to reflect progress through stages of completion and to amend estimated completion date in light of a required academic extension.

The record owner confirms that the information they have supplied for this submission is accurate and complete and they understand that deliberate provision of inaccurate information or omission of data may be construed as scientific misconduct.

The record owner confirms that they will update the status of the review when it is completed and will add publication details in due course.

Versions

06 May 2022

08 May 2022

11 August 2022

Are staff-initiated autonomous self-care interventions effective in reducing burnout in psychological practitioners?

Mr Alistair Merrick & Dr Mark Hoelterhoff (University of Edinburgh)

SYSTEMATIC REVIEW SEARCH STRATEGY:

IDENTIFICATION OF SEARCH TERMS:

Search terms were identified in line with the process outlined by Bramer et al. (2018). Following the confirmation of the key concepts examined by the research question, appropriate index terms were identified in each database. Relevant synonyms for these terms were next identified in the thesaurus of each respective database where available. Finally, database-appropriate syntax (Boolean operators, parentheses) was used to refine the list of search terms, and to account for variations of these terms due to regional language differences and variations on word endings (e.g. plurals). These lists of terms were further augmented following retrieval of initial scoping results by examining study keywords and abstracts for further relevant search terms, synonyms or spelling variations. Searches were repeated with and without inclusion of any new terms to enable assessment of whether their inclusion further optimised the search by resulting in additional potentially relevant studies being identified. The above steps were then repeated and translated for each database's appropriate search syntax requirements.

WORKED EXAMPLE (EMBASE):

Step 1

Identification of Relevant Index Terms:

- Population (Psychotherapists) = *Clinical psychology, psychologist, counsellor, psychotherapist.*
- Condition (Burnout) = *Job stress, burnout.*

Step 2

Identification of relevant synonyms/variations using e.g. Emtree, MeSH, Psychinfo etc.

- Population (Psychotherapists) = *psychiatric therapist, psychotherapists & therapist, psychiatric, clinical psychologist & psychologist, clinical & psychology, clinical, counsellor, counsellors, counsellors.*
- Condition (Burnout) = *burn-out, burn-out syndrome, psychological burn-out, burnout, psychological burnout, burnout syndrome, (burnout, psychological), professional burnout, occupational burnout, career burnout, job related stress, occupational stress, professional stress, job-related stress, work stress.*

Step 3

Translation/simplification into database-specific syntax while accounting for search term variations.

- (clinical psychology/ or psychologist/ or counsellor/ or psychotherapist/ or (Psychotherapist* or psychiatric therapist* or clinical psychotherapist* or clinical psychologist* or psychologist* or counsellor* or counselor* or counselling psychologist* or counseling psychologist* or psychotherapeutic counselor* or psychotherapeutic counsellor*)) and (job stress/ or burnout/ or (((Burn out or burn-out or burnout) and (psychological or syndrome or professional or occupational or career)) or ((stress* or distress) and (job related or job-related or job or occupational or professional or work or work-related or work related or workplace or work-place or work place or occupational or professional))))
- (Where / denotes the use of these EMBASE database index terms, and * denotes a wildcard symbol that broadens a search by finding words that start with the same letters. For example, *stress** would return “*stressed*”, “*stresses*” or “*stressors*”)

SEARCH STRATEGY/METHODOLOGY:

These terms will be used to search at minimum the article titles, keywords, abstracts (database dependent, will search wider metadata as applicable). Searches will be limited by publication date (1st January 1980 onwards to present), as relevant validated outcome measures for burnout were not available prior to this date. Searches will use no other limitations.

The following electronic bibliographic databases shall be searched - EMBASE, MEDLINE, APA PsychInfo, CINAHL, ASSIA, Scopus, ProQuest Dissertations and Theses, and Cochrane Library. The final lists of terms will be used to search under “keyword” within the OVID search interface (for EMBASE, MEDLINE and PsychINFO), “title-abstract-keyword” using Scopus, and “anywhere except full text” when accessing databases via ProQuest (ProQuest Dissertations and Theses, ASSIA). Searching both CINAHL via the EBSCOHost interface and The Cochrane Library Database will require multistage entry to first search for individual identified MeSH index terms, then remaining free text keywords, before combining them using Boolean search operators.

Following the initial search the reviewers will examine the reference lists of any relevant, previously published reviews or meta-analyses identified, as well as those studies included in the review, for potentially relevant studies. Further, relevant individuals and organisations identified within the studies selected for review will be contacted for information about unpublished or ongoing studies.

REFERENCES:

Bramer, W. M., de Jonge, G. B., Rethlefsen, M. L., Mast, F., & Kleijnen, J. (2018). A systematic approach to searching: An efficient and complete method to develop literature searches. *Journal of the Medical Library Association*, 106(4), 531–541. <https://doi.org/10.5195/jmla.2018.283>

SEARCH TERMS USED FOR EACH DATABASE:

EMBASE

(clinical psychology/ or psychologist/ or counsellor/ or psychotherapist/ or (Psychotherapist* or psychological therapist* or psychiatric therapist* or clinical psychotherapist* or clinical psychologist* or psychologist* or counsellor* or counselor* or counselling psychologist* or counseling psychologist* or psychotherapeutic counselor* or psychotherapeutic counsellor* or cognitive-behavioural therapist* or cognitive behavioural therapist* or cognitive-behavioral therapist* or cognitive behavioral therapist* or clinical social work*)) and (job stress/ or burnout/ or (((Burn out or burn-out or burnout) and (psychological or syndrome or professional or occupational or career)) or ((stress* or distress) and (job related or job-related or job or occupational or professional or work or work-related or work related or workplace or work-place or work place or occupational or professional)))) AND (Maslach Burnout Inventory/ OR Oldenburg Burnout Inventory/ OR ((Maslach* burnout OR Maslach* burn-out) AND (index OR inventor* OR questionnaire* OR scale* OR scores OR MBI)) OR ((Malach OR Malakh OR Pine* or Aronson*) AND (Burnout Measure OR Burn-out Measure OR burn out measure)) OR (psychologist* burnout inventory OR psychologist* burn-out inventory OR psychologist* burn out inventory OR (PBI AND (burnout or burn-out or burn out))) OR (Oldenburg AND (burnout inventory OR burn-out inventory OR burn out inventory OR inventory OR OLB I OR OBI)) OR (Copenhagen Burnout Inventory OR (Copenhagen AND (burnout inventory OR burn-out inventory OR burn out inventory or CBI))))

MEDLINE

(Psychotherapists/ or Counselors/ or Psychology/ or (Psychotherapist* or psychological therapist* or psychiatric therapist* or clinical psychotherapist* or clinical psychologist* or psychologist* or counsellor* or counselor* or counselling psychologist* or counseling psychologist* or psychotherapeutic counselor* or psychotherapeutic counsellor* or cognitive-behavioural therapist* or cognitive behavioural therapist* or cognitive-behavioral therapist* or cognitive behavioral therapist* or clinical social work*)) AND (occupational stress/ or burnout, professional/ or (((Burn out or burn-out or burnout) and (psychological or syndrome or professional or occupational or career)) or ((stress* or distress) and (job related or job-related or job or occupational or professional or work or work-related or work related or workplace or work-place or work place or occupational or professional)))) AND ((Maslach* burnout OR Maslach* burn-out) AND (index OR inventor* OR questionnaire* OR scale* OR scores OR MBI)) OR ((Malach OR Malakh OR Pine* or Aronson*) AND (Burnout Measure OR Burn-out Measure OR burn out measure)) OR (psychologist* burnout inventory OR psychologist* burn-out inventory OR psychologist* burn out inventory OR (PBI AND (burnout or burn-out or burn out))) OR (Oldenburg AND (burnout inventory OR burn-out inventory OR burn out inventory OR inventory OR OLB I OR OBI)) OR (Copenhagen Burnout Inventory OR (Copenhagen AND (burnout inventory OR burn-out inventory OR burn out inventory or CBI))))

APA PSYCHINFO

(counselors/ or psychologists/ or clinical psychologists/ or counseling psychologists/ or psychotherapists/ or (Psychotherapist* or psychological therapist* or psychiatric therapist* or clinical psychotherapist* or clinical psychologist* or psychologist* or counsellor* or counselor* or counselling psychologist* or counseling psychologist* or psychotherapeutic counselor* or psychotherapeutic counsellor* or cognitive-behavioural therapist* or cognitive behavioural therapist* or cognitive-behavioral therapist* or cognitive behavioral therapist* or clinical social work*)) AND (occupational stress/ or (((Burn out or burn-out or burnout) and (psychological or syndrome or professional or occupational or career)) or ((stress* or distress) and (job related or job-related or job or occupational or professional or work or work-related or work related or workplace or work-place or work place or occupational or professional)))) AND ((Maslach* burnout OR Maslach* burn-out) AND (index OR inventor* OR questionnaire* OR scale* OR scores OR MBI)) OR ((Malach OR Malakh OR Pine* or Aronson*) AND (Burnout Measure OR Burn-out Measure OR burn out measure)) OR (psychologist* burnout inventory OR psychologist* burn-out inventory OR psychologist* burn out inventory OR (PBI AND (burnout or burn-out or burn out))) OR (Oldenburg AND (burnout inventory OR burn-out inventory OR burn out inventory OR inventory OR OLB I OR OBI)) OR (Copenhagen Burnout Inventory OR (Copenhagen AND (burnout inventory OR burn-out inventory OR burn out inventory or CBI)))

CINAHL PLUS

S1 (MH "Psychotherapists")

S2 (MH "Counselors")

S3 (MH "Psychology")

S4 (Psychotherapist* or "psychological therapist*" or "psychiatric therapist*" or "clinical psychotherapist*" or "clinical psychologist*" or psychologist* or counsellor* or counselor* or "counselling psychologist*" or "counseling psychologist*" or "psychotherapeutic counselor*" or "psychotherapeutic counsellor*" or "cognitive-behavioural therapist*" or "cognitive behavioural therapist*" or "cognitive-behavioral therapist*" or "cognitive behavioral therapist*")

S5 (MH "Burnout, Professional")

S6 (MH "Occupational Stress")

S7 ((("Burn out" or burn-out or burnout) and (psychological or syndrome or professional or occupational or career)) or ((stress* or distress) and ("job related" or job-related or job or occupational or professional or work or work-related or "work related" or workplace or work-place or "work place" or occupational or professional)))

S8 ((("Maslach* burnout" OR "Maslach* burn-out") AND (index OR inventor* OR questionnaire* OR scale* OR scores OR MBI)) OR ((Malach OR Malakh OR Pine* or Aronson*) AND ("Burnout Measure" OR "Burn-out Measure" OR "burn out measure")) OR ("psychologist* burnout inventory" OR "psychologist* burn-out inventory" OR "psychologist* burn out inventory" OR (PBI AND (burnout or burn-out or "burn out")))) OR (Oldenburg AND ("burnout inventory" OR "burn-out inventory" OR "burn out inventory" OR inventory OR OLB I OR OBI)) OR ("Copenhagen Burnout Inventory" OR (Copenhagen AND ("burnout inventory" OR "burn-out inventory" OR "burn out inventory" or CBI)))

Final search = (((S1 or S2 or S3 or S4) AND (S5 or S6 or S7)) AND S8)

ASSIA (Applied Social Science Index and Abstracts)

(MAINSUBJECT.EXACT("Clinical psychologists" OR "counselling psychologists" OR "psychotherapists" OR "clinical social workers") OR (Psychotherapist* OR "psychological therapist*" OR "psychiatric therapist*" OR "clinical psychotherapist*" OR "clinical psychologist*" OR psychologist* OR counsellor* OR counselor* OR "counselling psychologist*" OR "counseling psychologist*" OR "psychotherapeutic counselor*" OR "psychotherapeutic counsellor*" OR "cognitive-behavioural therapist*" OR "cognitive behavioural therapist*" OR "cognitive-behavioral therapist*" OR "cognitive behavioral therapist*" OR "clinical social work*")) AND (MAINSUBJECT.EXACT("burnout" OR "Occupational stress") OR (((("Burn out" or burn-out or burnout) and (psychological or syndrome or professional or occupational or career)) or ((stress* or distress) and ("job related" or job-related or job or occupational or professional or work or work-related or "work related" or workplace or work-place or "work place" or occupational or professional)))) AND (((Maslach* burnout OR Maslach* burn-out) AND (index OR inventor* OR questionnaire* OR scale* OR scores OR MBI)) OR ((Malach OR Malakh OR Pine* or Aronson*) AND ("Burnout Measure" OR "Burn-out Measure" OR "burn out measure")) OR ("psychologist* burnout inventory" OR "psychologist* burn-out inventory" OR "psychologist* burn out inventory" OR (PBI AND (burnout or burn-out or "burn out")))) OR (Oldenburg AND ("burnout inventory" OR "burn-out inventory" OR "burn out inventory" OR inventory OR OLBI OR OBI)) OR ("Copenhagen Burnout Inventory" OR (Copenhagen AND ("burnout inventory" OR "burn-out inventory" OR "burn out inventory" or CBI))))

ProQuest Dissertation and Theses Global

(MAINSUBJECT.EXACT("Clinical psychologists" OR "counselling psychologists" OR "psychotherapists" OR "clinical social workers") OR (Psychotherapist* OR "psychological therapist*" OR "psychiatric therapist*" OR "clinical psychotherapist*" OR "clinical psychologist*" OR psychologist* OR counsellor* OR counselor* OR "counselling psychologist*" OR "counseling psychologist*" OR "psychotherapeutic counselor*" OR "psychotherapeutic counsellor*" OR "cognitive-behavioural therapist*" OR "cognitive behavioural therapist*" OR "cognitive-behavioral therapist*" OR "cognitive behavioral therapist*" OR "clinical social work*")) AND (MAINSUBJECT.EXACT("burnout" OR "Occupational stress") OR (((("Burn out" or burn-out or burnout) and (psychological or syndrome or professional or occupational or career)) or ((stress* or distress) and ("job related" or job-related or job or occupational or professional or work or work-related or "work related" or workplace or work-place or "work place" or occupational or professional)))) AND (((Maslach* burnout OR Maslach* burn-out) AND (index OR inventor* OR questionnaire* OR scale* OR scores OR MBI)) OR ((Malach OR Malakh OR Pine* or Aronson*) AND ("Burnout Measure" OR "Burn-out Measure" OR "burn out measure")) OR ("psychologist* burnout inventory" OR "psychologist* burn-out inventory" OR "psychologist* burn out inventory" OR (PBI AND (burnout or burn-out or "burn out")))) OR (Oldenburg AND ("burnout inventory" OR "burn-out inventory" OR "burn out inventory" OR inventory OR OLBI OR OBI)) OR ("Copenhagen Burnout Inventory" OR (Copenhagen AND ("burnout inventory" OR "burn-out inventory" OR "burn out inventory" or CBI))))

SCOPUS

((TITLE-ABS-KEY ((Psychotherapist* or “psychological therapist*” or “psychiatric therapist*” or “clinical psychotherapist*” or “clinical psychologist*” or psychologist* or counsellor* or counselor* or “counselling psychologist*” or “counseling psychologist*” or “psychotherapeutic counselor*” or “psychotherapeutic counsellor*” or “cognitive-behavioural therapist*” or “cognitive behavioural therapist*” or “cognitive-behavioral therapist*” or “cognitive behavioral therapist*” or “clinical social work*”)) AND TITLE-ABS-KEY (((“Burn out” or burn-out or burnout) and (psychological or syndrome or professional or occupational or career)) or ((stress* or distress) and (“job related” or job-related or job or occupational or professional or work or work-related or “work related” or workplace or work-place or “work place” or occupational or professional)))) AND TITLE-ABS-KEY (((“Maslach* burnout” OR “Maslach* burn-out”) AND (index OR inventor* OR questionnaire* OR scale* OR scores OR MBI)) OR ((Malach OR Malakh OR Pine* or Aronson*) AND (“Burnout Measure” OR “Burn-out Measure” OR “burn out measure”)) OR (“psychologist* burnout inventory” OR “psychologist* burn-out inventory” OR “psychologist* burn out inventory” OR (PBI AND (burnout or burn-out or “burn out”))) OR (Oldenburg AND (“burnout inventory” OR “burn-out inventory” OR “burn out inventory” OR inventory OR OLBI OR OBI)) OR (“Copenhagen Burnout Inventory” OR (Copenhagen AND (“burnout inventory” OR “burn-out inventory” OR “burn out inventory” or CBI)))))

COCHRANE LIBRARY

#1 MeSH descriptor: [Psychotherapists] explode all trees

#2 MeSH descriptor: [Counselors] explode all trees

#3 MeSH descriptor: [Psychology] explode all trees

#4 (Psychotherapist* or “psychological therapist*” or “psychiatric therapist*” or “clinical psychotherapist*” or “clinical psychologist*” or psychologist* or counsellor* or counselor* or “counselling psychologist*” or “counseling psychologist*” or “psychotherapeutic counselor*” or “psychotherapeutic counsellor*” or “cognitive-behavioural therapist*” or “cognitive behavioural therapist*” or “cognitive-behavioral therapist*” or “cognitive behavioral therapist*”)

#5 MeSH descriptor: [Burnout, Professional] explode all trees

#6 MeSH descriptor: [Occupational Stress] explode all trees

#7 ((“Burn out” or burn-out or burnout) and (psychological or syndrome or professional or occupational or career)) or ((stress* or distress) and (“job related” or job-related or job or occupational or professional or work or work-related or “work related” or workplace or work-place or “work place” or occupational or professional))

#8 ((“Maslach* burnout” OR “Maslach* burn-out”) AND (index OR inventor* OR questionnaire* OR scale* OR scores OR MBI)) OR ((Malach OR Malakh OR Pine* or Aronson*) AND (“Burnout Measure” OR “Burn-out Measure” OR “burn out measure”)) OR (“psychologist* burnout inventory” OR “psychologist* burn-out inventory” OR “psychologist* burn out inventory” OR (PBI AND (burnout or burn-out or “burn out”))) OR (Oldenburg AND (“burnout inventory” OR “burn-out inventory” OR “burn out inventory” OR inventory OR OLBI OR OBI)) OR (“Copenhagen Burnout Inventory” OR (Copenhagen AND (“burnout inventory” OR “burn-out inventory” OR “burn out inventory” or CBI))

Final search = (((#1 or #2 or #3 or #4) AND (#5 or #6 or #7)) AND #8)

Appendix D: Systematic Review Quality Scoring and Item Modifications from Original Q-SSP.

The following outlines the modification of the Quality of Survey Studies in Psychology Checklist (Q-SSP) (Protogerou & Hagger, 2020) for use in the present study. Original items are referenced in the original paper.

1. Some reduction in the original Q-SSP items occurred for parsimony and based on relevance to this study:
 - Original Q-SSP items 13, 14 and 15 were combined into the new question *“was the data collection procedure (persons, places, methods and duration) specified sufficiently to enable exact replication?”*.
 - Original items 1 and 4 were combined into *“were all study variables defined and justified for examination?”*.
 - Original items 8 and 9 were removed entirely, as they related to attrition rate and so were deemed irrelevant for cross-sectional studies with no follow-up period or recruitment waves as exclusively identified by this review.
 - Original item 11 was removed (*“were the measures provided in the report (or in a supplement) in full?”*), as this may bias evaluation of quality, given some measures of burnout (e.g. the MBI) are copyrighted and hence unable to be reproduced in full by other authors (Mind Garden Inc., 2022).
2. Some items were added to the original measure:
 - One new item was included To address bias due to confounding not addressed by the Q-SSP (*“Were confounding variables taken into account in the design and/or analysis?”*). This wording was chosen having been proposed as representative of equivalent items included within 62 observational study assessment tools in a review by Z. Wang et al. (2019).
 - An additional ethics item originally included in the Q-SSP, but removed, was re-added (*“was the study approved by a relevant institutional review board or research ethics committee?”*). While noting the original authors’ points that not all academic departments or countries may have ethics committees, and that survey designs may in any case prove exempt (Protogerou & Hagger, 2020), formal oversight nonetheless remains a predominant ethical recommendation in research conducted with human participants (BPS, 2021; World Medical Association, 2013).
 - Finally, due to ambiguous wording, Q-SSP item 10 (*“Were the data analysis techniques justified...?”*) was replaced with two new questions thought to more specifically address reporting bias (*“were the results of all test outcomes and statistical analysis fully reported regardless of statistical significance?”* and *“were all tests of hypotheses outlined and specified a-priori?”*).

The preceding modifications resulted in a final list of 17 items, originally grouped into “Introduction”, “Participants”, “Data” and “Ethics” subdomains in line with the original measure. To better align with the key sources of potential bias identified for observational studies (Sterne et al., 2022; Z. Wang et al., 2019), all items were reclassified into new domains of Information & Measurement, Selection, Reporting, Ethics, and Confounding.

Scoring: The original Q-SSP scoring was retained, with items scored 1 for “yes”, and a zero for “no / not stated clearly” depending on the degree to which the study demonstrates the referenced criteria. Whole studies or individual quality domains can be evaluated by dividing the number of “yes” responses by the total number of quality assessment or domain items respectively. Attaining a score of >70% overall, or >75% for any given domain, is considered as demonstrating “acceptable” quality, with anything below these cut-offs deemed “questionable”.

Appendix E: Studies Excluded from Systematic Review Following Full-Text Review, Including Reasons for Non-Inclusion.

Study	Exclusion Reason
Ackerley, G. D., Burnell, J., Holder, D. C., & Kurdek, L. A. (1988). Burnout Among Licensed Psychologists. <i>Professional Psychology: Research and Practice</i> , 19(6), 624–631. https://doi.org/10.1037/0735-7028.19.6.624	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Aksamit, P. (1997). An investigation of burnout in substance abuse treatment providers [University of Idaho]. In <i>ProQuest Dissertations and Theses</i> .	Combination of multiple listed exclusion reasons (Ineligible Sample population and lack of eligible intervention/correlate).
Amrani, P. (2010). Loving-kindness: Self-compassion, burnout and empathy among therapists. <i>ProQuest Dissertations and Theses</i> .	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Aragones, A. O. (1999). Burnout among doctoral-level psychologists: A study of coping alternatives. In <i>ProQuest Dissertations and Theses</i> .	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Barnett, N. G. (2015). The relationship of wellness and wellness practices to burnout among counselors and counselors-in-training [Mercer University]. In <i>ProQuest Dissertations and Theses</i> (Issues 10103387 PG-177).	Ineligible study design.
Beck, D. F. (1987). Counselor Burnout in Family Service Agencies. <i>Social Casework</i> . https://doi.org/10.1177/104438948706800101	Full text not available despite best efforts of review team
Berjot, S., Altintas, E., Lesage, F. X., & Grebot, E. (2017). Burnout risk profiles among French psychologists. <i>Burnout Research</i> , 7, 10–20. https://doi.org/10.1016/j.burn.2017.10.001	Combination of multiple listed exclusion reasons (Ineligible study design and lack of eligible intervention/correlate).
Bilot, J. (2012). The relationship between wellness and burnout among novice counselors [Florida Atlantic University]. In <i>ProQuest Dissertations and Theses</i> (Issues 3530689 PG-109).	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Bock, J. P. (2009). The relationship between mindfulness and burnout in psychotherapists: An exploratory study [The University of the Rockies]. In <i>ProQuest Dissertations and Theses</i> (Issues 3372772 PG-83).	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Bohnenstiehl, A. K. (2019). Supervisory Working Alliance as a Predictor for Counselor Burnout: The Potential Mediating Role of Supervisee Nondisclosure [University of Missouri - Saint Louis]. In <i>ProQuest Dissertations and Theses</i> (Issues 27668426 PG-101).	Combination of multiple listed exclusion reasons (Ineligible Sample population and lack of eligible intervention/correlate).

Study	Exclusion Reason
Brewer, D. P. (1994). The effects of supervisory support, counselor characteristics, the work setting, and social influences on burnout in mental health counselors [University of Cincinnati]. In <i>ProQuest Dissertations and Theses</i> (Issues 9502552 PG-175).	Combination of multiple listed exclusion reasons (Ineligible Sample population and lack of eligible intervention/correlate).
Caruso, C., Costantini, M., & Mezzaluna, C. (2017). The role of supervision in preventing burnout among psychotherapists: A pilot study. <i>Psicoterapia Cognitiva e Comportamentale</i> , 23(3 PG-317–330), 317–330.	Full text not accessible in English
D'Souza, F., Egan, S. J., & Rees, C. S. (2011). The relationship between perfectionism, stress and burnout in clinical psychologists. <i>Behaviour Change</i> , 28(1), 17–28. https://doi.org/10.1375/bech.28.1.17	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Dannett, K. S. (1985). Stress and Strain in the Practice of Psychotherapy (Burnout) [New School for Social Research]. In <i>ProQuest Dissertations and Theses</i> (Issues 8521548 PG-125).	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Di Benedetto, M., & Swadling, M. (2014). Burnout in Australian psychologists: Correlations with work-setting, mindfulness and self-care behaviours. <i>Psychology, Health and Medicine</i> , 19(6), 705–715. https://doi.org/10.1080/13548506.2013.861602	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Dorociak, K. E., Rupert, P. A., & Zahniser, E. (2017). Work Life, well-being, and self-care across the professional lifespan of psychologists. <i>Professional Psychology: Research and Practice</i> , 48(6), 429–437. https://doi.org/10.1037/pro0000160	Ineligible study design.
Ducharme, L. J., Knudsen, H. K., & Roman, P. M. (2007). Emotional exhaustion and turnover intention in human service occupations: the protective role of coworker support. <i>Sociological Spectrum</i> , 28(1), 81–104. https://doi.org/10.1080/02732170701675268	Ineligible sample population.
Egan, J. B. (2006). Burnout in female counsellor/therapists of the NCS. [University of Hull (United Kingdom)]. In <i>PQDT - UK & Ireland</i> (Issue U230561 PG-1).	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Ellis, D. S. (2019). Exploring The Mediating Effects Between Counselor Self-Efficacy, Career Sustaining Behaviors, Perceived Wellness, and Burnout Among Novice Counselors: Testing Two Proposed Mediation Models [Sam Houston State University]. In <i>ProQuest Dissertations and Theses</i> (Issues 27603057 PG-137).	Ineligible study design.
Farber, B. A. (1985). Clinical psychologists' perceptions of psychotherapeutic work. <i>Clinical Psychologist</i> , 38(1), 10–13. https://psycnet.apa.org/record/1985-21176-001	Combination of multiple listed exclusion reasons (No eligible intervention measures, ineligible survey design).

Study	Exclusion Reason
Fearon, R. (2021). Understanding Factors Contributing to Burnout in Private Practice Settings [Holy Family University]. In <i>ProQuest Dissertations and Theses</i> (Issues 28548830 PG-69).	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Fourie, L., Rothmann, S., & van de Vijver, F. J. R. (2008). A model of work wellness for non-professional counsellors in South Africa. <i>Stress and Health</i> , 24(1), 35–47. https://doi.org/10.1002/SMI.1163	Ineligible sample population.
Ganey, K. R. (2004). Resilience and emotional depletion as predictors of dyadic satisfaction of psychologists in Pennsylvania [George Fox University]. In <i>ProQuest Dissertations and Theses</i> (Issues 3158654 PG-80).	Combination of multiple listed exclusion reasons (No eligible intervention/self-care measures, burnout not included as a study outcome variable).
Hardiman, P., & Simmonds, J. G. (2013). Spiritual well-being, burnout and trauma in counsellors and psychotherapists. <i>Http://Dx.Doi.Org/10.1080/13674676.2012.732560</i> , 16(10), 1044–1055. https://doi.org/10.1080/13674676.2012.732560	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Hatfield, K. (2000). Exploring Counsellor Burnout and Personal Accomplishment in Organisations that Empower Abused Women [University of Johannesburg (South Africa)]. In <i>PQDT - Global</i> (Issues 28372219 PG-99).	Ineligible sample population
Hiebler-Ragger, M., Gollner, C., Klampfl, P., Nausner, L., & Unterrainer, H. F. (2018). Integrative gestalt therapy in Austria. Training and professional conditions, sense of coherence and burnout. <i>Psychotherapeut</i> , 63(2), 145–152. https://doi.org/10.1007/S00278-017-0245-1/TABLES/3	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Hoeksma, J. H., Guy, J. D., Brown, C. K., & Brady, J. L. (1993). The relationship between psychotherapist burnout and satisfaction with leisure activities. <i>Psychotherapy in Private Practice</i> , 12(4 PG-51–57), 51–57.	Full text not available despite the best efforts of the review team.
Johnson, C. N. E., & Hunter, M. (1997). Vicarious traumatization in counsellors working in the New South Wales Sexual Assault Service: An exploratory study. <i>Work and Stress</i> , 11(4), 319–328. https://doi.org/10.1080/02678379708252995	Ineligible study design.
Krogh, K. E. J. (1996). The relations between gender roles, boundary permeability, and burnout in psychologists. <i>Dissertation Abstracts International: Section B: The Sciences and Engineering</i> , 57(2-B PG-1445), 1445.	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Kruger, L. J., Botman, H. I., & Goodenow, C. (1991). An investigation of social support and burnout among residential counselors. <i>Child & Youth Care Forum</i> , 20(5), 335–352. https://doi.org/10.1007/BF00757062	Ineligible sample population

Study	Exclusion Reason
Lee, S. K. (1986). The relation of self-perception of altruism, limit setting and job satisfaction to burnout among clinical psychologists [California School of Professional Psychology - Los Angeles]. In <i>ProQuest Dissertations and Theses</i> (Issues 8704344 PG-171).	Full text not available despite the best efforts of the review team.
Lushington, K., & Luscari, G. (2001). Are counseling students stressed? A cross-cultural comparison of burnout in Australian, Singaporean and Hong Kong counseling students. <i>Asian Journal of Counselling</i> , 8(2), 209–232. https://psycnet.apa.org/record/2002-06879-008	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Malinowski, A. J. (2009). The moderating effects of humor on job burnout among mental health therapists: A multiple regression analysis approach [Capella University]. In <i>ProQuest Dissertations and Theses</i> (Issues 3369472 PG-148).	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Malinowski, A. J. (2013). Characteristics of job burnout and humor among psychotherapists. <i>Humor</i> , 26(1), 117–133. https://doi.org/10.1515/humor-2013-0007	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Matyushkina, E. Y., & Kantemirova, A. A. (2019). Professional burnout and reflection of helping professionals. <i>Konsul'tativnaia Psikhologiya i Psikhoterapiia</i> , 27(2 PG-50–68), 50–68. https://doi.org/https://dx.doi.org/10.17759/cpp.2019270204	Combination of multiple listed exclusion reasons (Not available in English, ineligible study population – according to English abstract).
McCade, D., Frewen, A., & Fassnacht, D. B. (2021). Burnout and depression in Australian psychologists: The moderating role of self-compassion. https://doi.org/10.1080/00050067.2021.1890979 , 56(2), 111–122.	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
McCrone, C. (2021). The contribution of self-compassion and core self-evaluations on burnout among licensed professional counselors. <i>Dissertation Abstracts International: Section B: The Sciences and Engineering</i> , 82(12-B PG-No-Specified).	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
McKenzie, R. T. (1999). The influence of managed care involvement on the perceived occupational hazards, rewards, career-sustaining behaviors, and burnout of psychotherapists [The Fielding Institute]. In <i>ProQuest Dissertations and Theses</i> (Issues 9944053 PG-178).	Combination of multiple listed exclusion reasons (ineligible study design, no eligible intervention variable).
Moore, K. (1991). The relationship between therapists' attributions for therapy outcomes and therapist burnout: The role of situation-specific attributions [University of Missouri - Columbia]. In <i>ProQuest Dissertations and Theses</i> (Issues 9133621 PG-184).	Full text not available despite the best efforts of the review team.

Study	Exclusion Reason
Newton, T. L., Ohrt, J. H., Guest, J. D., & Wymer, B. (2020). Influence of Mindfulness, Emotion Regulation, and Perceived Social Support on Burnout. <i>Counselor Education and Supervision</i> , 59(4), 252–266. https://doi.org/10.1002/ceas.12187	Ineligible study population.
Persing, J. M. (2000). An exploration of the effects of spirituality on psychologist burnout. <i>Dissertation Abstracts International: Section B: The Sciences and Engineering</i> , 61(1-B PG-545), 545.	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Reis, D., Schröder, A., & Schlarb, A. (2014). Wohlbefinden, Burn-out und Ressourcen bei Psychotherapeuten [Well-being, burnout and resources in psychotherapists]. <i>Psychotherapeut</i> , 59(1), 46–51. https://doi.org/10.1007/s00278-013-0970-z	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Richardson, C. M. E., Trusty, W. T., & George, K. A. (2020). Trainee wellness: self-critical perfectionism, self-compassion, depression, and burnout among doctoral trainees in psychology. <i>Counselling Psychology Quarterly</i> , 33(2), 187–198. https://doi.org/10.1080/09515070.2018.1509839	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Rohman, C. R. (1987). A study of burnout among psychologists [Rutgers The State University of New Jersey - New Brunswick]. In <i>ProQuest Dissertations and Theses</i> (Issues 8727328 PG-141).	Full text not available despite the best efforts of the review team.
Roncalli, S., & Byrne, M. (2016). Relationships at work, burnout and job satisfaction: A study on Irish psychologists. <i>Mental Health Review Journal</i> , 21(1), 23–36. https://doi.org/10.1108/MHRJ-01-2015-0002	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Rupert, P. A., & Dorociak, K. E. (2019). Self-care, stress, and well-being among practicing psychologists. <i>Professional Psychology: Research and Practice</i> , 50(5), 343–350. https://doi.org/10.1037/pro0000251	Relevant results reported by previous study with shared sample
Rupert, P. A., Tuminello Hartman, E. R., & Oscharoff Miller, A. S. (2013). Work demands and resources, work-family conflict, and family functioning among practicing psychologists. <i>Professional Psychology: Research and Practice</i> , 44(5), 283–289. https://doi.org/10.1037/a0034494	Combination of multiple listed exclusion reasons (Burnout not considered as an outcome variable, no eligible intervention variable).
Rupert, P. A., Stevanovic, P., & Hunley, H. A. (2009). Work-Family Conflict and Burnout Among Practicing Psychologists. <i>Professional Psychology: Research and Practice</i> , 40(1), 54–61. https://doi.org/10.1037/a0012538	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Russ, S. (2018). Trainee therapist goal conflict and its relationship to perceptions of goal attainment and occupational stress [University of London, University College London (United Kingdom)]. In <i>PQDT - UK & Ireland</i> (Issues 11000813 PG-).	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).

Study	Exclusion Reason
Shapiro, A. B. (2013). Burnout, vicarious traumatization and mindfulness in clinicians [Palo Alto University]. In <i>ProQuest Dissertations and Theses</i> (Issues 3591878 PG-107).	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Shelton, R. R. (2001). Ego defenses as buffers against stress and burnout in clinical psychologists [Pepperdine University]. In <i>ProQuest Dissertations and Theses</i> (Issues 3036796 PG-211).	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Simnacher, C. E. (2021). Daily Spiritual Experiences, Empathy, and Sense of Belonging as Predictors of Burnout Among Licensed Counselors [New Orleans Baptist Theological Seminary]. In <i>ProQuest Dissertations and Theses</i> (Issues 28493774 PG-132).	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Simpson, S., Simionato, G., Smout, M., van Vreeswijk, M. F., Hayes, C., Sougleris, C., & Reid, C. (2019). Burnout amongst clinical and counselling psychologist: The role of early maladaptive schemas and coping modes as vulnerability factors. <i>Clinical Psychology and Psychotherapy</i> , 26(1), 35–46. https://doi.org/10.1002/cpp.2328	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Smolanoff, J. A. (1982). Coping strategies utilized by successfully-functioning clinicians [Bryn Mawr College]. In <i>ProQuest Dissertations and Theses</i> (Issues 8302188 PG-224).	Full text not available despite the best efforts of the review team.
Steel, C., Macdonald, J., Schröder, T., & Mellor-Clark, J. (2015). Exhausted but not cynical: Burnout in therapists working within Improving Access to Psychological Therapy Services. <i>Journal of Mental Health</i> , 24(1), 33–37. https://doi.org/10.3109/09638237.2014.971145	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Strickler, J. R. (1986). The relationship between psychotherapist burnout and leisure [California School of Professional Psychology - Los Angeles]. In <i>ProQuest Dissertations and Theses</i> (Issues 8626148 PG-192).	Full text not available despite the best efforts of the review team.
Tamura, L. J., Guy, J. D., Brady, J. L., & Grace, C. (1994). Psychotherapists' management of confidentiality, burnout and affiliation needs: A national survey. <i>Psychotherapy in Private Practice</i> , 13(2 PG-1–17), 1–17.	Full text not available despite the best efforts of the review team.
Teran, V. G., Fuentes, M. A., Atallah, D. G., & Yang, Y. (2017). Risk and protective factors impacting burnout in bilingual, Latina/o clinicians: An exploratory study. <i>Professional Psychology: Research and Practice</i> , 48(1), 22–29. https://doi.org/10.1037/pro0000126	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Testa, D. S. (2014). An empirical study on the association of mindfulness and emotional intelligence to burnout among counselors-in-training [The University of Akron]. In <i>ProQuest Dissertations and Theses</i> (Issues 3680510 PG-174).	Duplicate missed at screening.

Study	Exclusion Reason
Testa, D., & Sangganjanavanich, V. F. (2016). Contribution of Mindfulness and Emotional Intelligence to Burnout Among Counseling Interns. <i>Counselor Education and Supervision</i> , 55(2), 95–108. https://doi.org/10.1002/CEAS.12035	Ineligible study design.
Thomas, J. T., & Otis, M. D. (2010). Intrapsychic Correlates of Professional Quality of Life: Mindfulness, Empathy, and Emotional Separation. <i>Journal of the Society for Social Work and Research</i> , 1(2), 83–98. https://doi.org/10.5243/jsswr.2010.7	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).
Viehl, C., McCullough, R., Dispenza, F., & Guvensel, K. (2017). Burnout among sexual minority mental health practitioners: Investigating correlates and predictors. <i>Psychology of Sexual Orientation and Gender Diversity</i> , 4(3), 354–361. https://doi.org/10.1037/sgd0000236	Combination of multiple listed exclusion reasons (no eligible intervention variable, ineligible sample population).
Vilardaga, R., Luoma, J. B., Hayes, S. C., Pistorello, J., Levin, M. E., Hildebrandt, M. J., Kohlenberg, B., Roget, N. A., & Bond, F. (2011). Burnout among the addiction counseling workforce: The differential roles of mindfulness and values-based processes and work-site factors. <i>Journal of Substance Abuse Treatment</i> , 40(4), 323–335. https://doi.org/10.1016/j.jsat.2010.11.015	Combination of multiple listed exclusion reasons (no eligible intervention variable, ineligible sample population).
Zahratka, C. (2010). Dialectical behavior therapy: The effect of the consultation team on potential therapist burnout. <i>Dissertation Abstracts International: Section B: The Sciences and Engineering</i> , 71(6-B PG-3951), 3951.	No eligible intervention or correlate (no variable which can be defined as a self-care behaviour/strategy).

Appendix F: Table Summarising Reviewed Study Quality Criteria.

Study Name	Adams (2018)	Cline (2016)	Crescenzo (2021)	Deters (2008)	Dorociak (2017)	Elliott (2021)	Emery (2009)	Estassi (2009)	Flournoy (1990)	Kotera (2021)	Nissan (2021)	Richards (2018)	Roper- Ericson (2002)	Rupert (2007)	Rzeszutek (2014)	Santana (2017)	Shoyer (1998)	Zeidan- Lukacs (2013)
Risk of Bias Domains/Items																		
Information and Measurement																		
1. All study variables defined & justified.	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
2. Rationale provided for sample size.	1	0	0	0	0	1	0	0	0	1	1	1	1	0	0	1	0	0
3. Evidenced validity of measures used.	1	0	0	0	1	0	1	0	0	0	0	0	1	0	0	1	0	1
4. Data collection adequately described.	1	0	0	1	0	1	0	0	0	0	0	1	1	0	0	0	0	0
Selection																		
1. Sample population defined/justified.	1	1	0	1	1	1	1	1	1	0	0	1	1	1	1	1	1	1
2. Participant inclusion criteria stated.	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
3. Recruitment strategy described.	0	0	0	0	0	1	1	0	1	1	0	0	1	0	0	0	1	1
4. Key sample demographics described.	1	1	0	0	1	1	0	0	1	1	1	1	1	0	0	1	1	1
Reporting																		
1. Research questions/hypotheses stated.	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
2. Statistical results fully reported.	0	0	1	0	0	1	1	0	1	1	0	0	0	0	0	0	0	1
3. All hypothesis tests outlined a priori.	1	1	0	1	1	1	1	0	1	1	0	1	0	1	1	1	0	1
4. Findings discussed only re: population.	0	1	0	1	1	0	1	1	1	1	0	0	1	1	1	1	1	1
Ethics																		
1. informed participant consent obtained.	1	1	0	1	0	1	0	1	0	1	1	1	0	0	0	0	1	1
2. Participants debriefed.	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Funding / conflicts of interest declared.	0	1	1	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0
4. Ethical approval obtained / reported.	1	1	1	1	1	1	0	1	0	1	0	1	0	0	0	1	0	0
Confounding																		
1. Confounding variables accounted for in design and/or analysis.	0	0	0	0	0	0	1	0	1	1	0	1	0	0	0	0	1	0
Overall Study Quality (%)																		
	A (70.6)	Q (58.8)	Q (35.3)	Q (52.9)	Q (52.9)	A (70.6)	Q (58.8)	Q (41.1)	Q (58.8)	A (76.5)	Q (35.3)	Q (64.7)	Q (64.7)	Q (35.3)	Q (41.1)	Q (58.8)	Q (52.9)	Q (64.7)

Key. 1 = study met specified quality assessment criteria; 0 = study did not meet specified quality assessment criteria; Highlighted green = study demonstrated “acceptable” overall domain quality, having scored “1”s for 75% or more of the total domain quality assessment items; Highlighted red = “questionable” overall domain quality, having scored “1”s less than 75% of the total domain quality assessment items; A = study overall demonstrated “acceptable” quality having scored “1”s for 70% or more of the total quality assessment items; Q = study overall demonstrated “questionable” quality having scored “1”s for less than 70% of the total quality assessment items. (%) indicates total quality items endorsed divided by scale total (17), to give an estimate of each studies overall quality as a percentage of the possible maximum score.

Appendix G: Participation and Consent Information Provided to Survey Respondents.

Is psychological practitioners' self-care self-determined?
V3 - 22.09.21



PARTICIPANT INFORMATION SHEET

Is psychological practitioners' self-care self-determined?

The roles of motivation, workload, stigma, high standards, and self-sacrifice.

You are invited to take part in research on how psychological practitioners self-care. Alistair Merrick (University of Edinburgh/NHS Forth Valley) is leading this research, supervised by Dr Mark Hoeltermhoff (University of Edinburgh) and Dr. Susan Ramsay (NHS Forth Valley). Before going further, it is important you understand why this research is happening and what it involves. Please read the following information carefully.

WHAT IS THE STUDY PURPOSE?

Research shows psychological practitioners risk experiencing psychological distress and burnout (emotional, physical, and mental exhaustion) at work. Also, fixing these issues is likely harder than preventing them. Research therefore recommends supporting psychological practitioners to practice preventative self-care.

Self-care describes any behaviours or strategies which can increase health and wellbeing at work or at home. Examples could include speaking with work colleagues for support or finding time for daily relaxation. However, research has found that many psychological practitioners experience barriers to self-care. Some barriers are job-related, such as having a high workload, or being concerned about experiencing stigma if admitting or discussing personal issues requiring self-care. Research has also found psychological practitioners often hold themselves to high personal performance standards and prioritise caring for others over themselves. We are also interested to know what motivates psychological practitioners to self-care, as health behaviour research shows us this could have an impact.

This study therefore aims to explore these factors to find out what makes it more or less likely that psychological practitioners will self-care.

WHY HAVE I BEEN INVITED?

You are invited to participate because you are currently employed as a psychological practitioner in a clinical role. This may be as a trainee or qualified staff member, or in a pre-qualification role. (e.g. *Clinical/Counselling Psychologist, Other Accredited Therapist, Clinical Associate in Applied Psychology, Psychological Wellbeing Practitioner, Primary Care Mental Health Worker, or Assistant Psychologist*).

You can take part if you:

- Are fluent in English
- Have normal vision (or vision corrected to normal using e.g. glasses/contact lenses)
- Have been working for at least the past 2 months in one or some combination of the above roles (with no significant recent absences longer than 1 month).
- Are employed by a UK-based health or social care organisation, either public or third sector.
- Do NOT work solely in private practice.



DO I HAVE TO TAKE PART?

No – it is entirely up to you. If you do take part, you are still free to stop at any time during the survey and without giving a reason.

To maintain anonymity as fully as possible, no name or contact information will be required, and no identifier codes will be assigned to you. This means that once you have completed the survey, the researchers will not be able to withdraw your answers. Please ensure you are happy with this before taking part.

Please note that deciding not to take part or withdrawing from the study will not affect your employment or course of study in any way.

WHAT WILL HAPPEN IF I DECIDE TO TAKE PART?

You will first be asked some screening questions to make sure you are eligible to take part. You will then get to read through a consent form and confirm you are happy to take part on the consent screen. You will then be asked some multiple response questions. The first questions will be about you (e.g. age, gender). These are only asked so we can confirm consistency in our results. The remaining questions ask about types of self-care strategies you may use, how you experience motivation towards self-care, your experience at work (perceived workload, attitudes regarding stress/burnout in your workplace), your attitudes regarding your general performance, and how much you generally prioritise yourself vs. others.

All responses are anonymous and will not be shared with anyone outside the research team. It should not be possible for anyone from the research team to identify you. However, if you know or work alongside any named researchers, and are concerned your answers may make you identifiable to them, please fully consider whether you wish to proceed on this basis.

The research takes place completely online using the Qualtrics survey platform. You may complete the survey at any time which is most convenient for you. The survey should take about 25 minutes to complete, including reading this participant information and completing the consent process.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

There are no direct benefits, but by sharing your experiences with us, you will be helping the researchers better understand what supports or prevents psychological practitioners' self-care. It is hoped this information can support service improvements or further research which may benefit psychological practitioners, their services, and their patients.

ARE THERE ANY RISKS OR DISADVANTAGES ASSOCIATED WITH TAKING PART?

There are no significant risks associated with participation. You may however find it upsetting thinking about stressors in the workplace or your own possible difficulties practicing self-care.

The online survey form will therefore include a "withdraw" button at the end of each question section. Selecting and confirming "withdraw" will take you to the survey's end, your previous answers will be withdrawn and deleted, and you will have an opportunity to anonymously provide feedback. **PLEASE NOTE:** If you leave the survey uncompleted via any other means than using the "withdraw" button (e.g., by closing your web browser and not returning) your data will be retained as an incomplete response and may be included in data analysis.



Whether you complete the survey or withdraw, you will be provided information about what you can do if you experience any distress, or if you wish to make a complaint. **PLEASE NOTE:** You will only be provided access to this information by either completing the study or using the "withdraw" button provided.

Please finally be advised, to ensure people keep place when completing their online survey, as well as to prevent multiple responses, the Qualtrics website will use GDPR compliant browser cookies. These cannot be used by the research team for the purposes of identification.

WILL MY TAKING PART BE KEPT CONFIDENTIAL?

The University of Edinburgh is the sponsor for this study based in the United Kingdom. We will be using information from you to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly.

Your data will be processed in accordance with Data Protection Law. All information collected about you will be kept strictly confidential and will be completely anonymous. Your data will only be viewed by the researchers named at the start of this sheet, though primarily they will be viewed by Alistair Merrick alone. All electronic data will be stored as password-protected computer files on secure University of Edinburgh cloud servers.

Once the research is completed, this data will be transferred to secure online storage provided by the University of Edinburgh and stored anonymously for a minimum of 10 years by the supervising researcher (Dr. Mark Hoelterhoff). It may also be uploaded to an online repository so that other researchers can use it in future research projects, though to gain access they will be required to complete an ethical approval process.

For general information about how we use your data go to:
<https://www.ed.ac.uk/records-management/privacy-notice-research>

WHAT WILL HAPPEN WITH THE RESULTS OF THIS STUDY?

The results of this study will be written up as a thesis for Alistair Merrick to complete the Doctorate in Clinical Psychology programme. Results may also be summarised in published articles, reports and presentations. You will not be identifiable from any published results. A summary of the findings from the study will be made available to participants upon request. If you wish to receive this summary please contact Dr. Mark Hoelterhoff (see email address below).

WHO IS ORGANISING AND FUNDING THE RESEARCH? - This study has been organised by Alistair Merrick for the Doctorate in Clinical Psychology. This study will be sponsored by the University of Edinburgh. This study is not funded.

WHO HAS REVIEWED THE STUDY? The study proposal has been reviewed by The University of Edinburgh School of Health in Social Science Ethics Committee and the NHS management approval has been granted.



WHO CAN I CONTACT?

If you have any further questions about the study, please contact the lead researcher, **Alistair Merrick** –

If you wish to be provided with a summary of research findings once the study is over, please contact **Dr Mark Hoelterhoff (Academic Research Supervisor)** -

If you would like to discuss this study with someone independent of the research team please contact **Dr. Angus Macbeth (Research Director, Doctorate of Clinical Psychology)** -

If you wish to make a complaint about the study, please contact **Dr. Matthias Schwannauer (Head of School for Health and Social Sciences)** -
(In your email please include the study title and the nature of your complaint).

**PLEASE DOWNLOAD, SCREENSHOT, OR OTHERWISE RETAIN
THIS INFORMATION SHEET FOR YOUR RECORDS.**

CONSENT AGREEMENT:

- I have read and understood the Participant Information Sheet (Version 3, 22nd September 2021) for this study.
- I have been given the opportunity to consider the information provided, ask questions, and have had these questions answered to my satisfaction. I understand that my participation is voluntary, and I can stop the study at any point without my employment or course of study being affected.
- I understand that it will not be possible to withdraw my data once I have submitted my responses at the end.
- I understand that my anonymous data will be stored on an online repository for a minimum of 10 years and may be used for future ethically approved research.
- I understand that relevant sections of my data collected during the study may be looked at by individuals from the Sponsor (University of Edinburgh) or from the NHS Board, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.

By ticking this box I agree to all the above consent points and agree to take part in this study. •

Please tick here if you do not wish to consent. •

Appendix H: Study Background and Rationale Document Provided to Survey Respondents.



THE UNIVERSITY of EDINBURGH School of Health in Social Science

PARTICIPANT DEBRIEFING SHEET – STUDY BACKGROUND & RATIONALE

*Is psychological practitioners' self-care self-determined?
The roles of motivation, workload, stigma, high standards, and self-sacrifice.*

1. The Wellbeing of Psychological Practitioners – Background and Current Context:

Psychological practitioners working in UK health services have been identified as an at-risk professional group, demonstrating general well-being below the national average (Summers et al., 2020).

Following COVID-19, public demand for mental health services has increased, service demands have arisen to expand psychological support within the healthcare workforce, and both demands are projected to rise further (British Medical Association, 2020b; Durcan et al., 2020; Greenberg et al., 2020; Office for National Statistics, 2020; Royal College of Psychiatrists, 2020). In both psychological practitioners and the wider mental health workforce, increased work demands and reduced control/clarity at work have been identified as significant contributors to burnout (K. O'Connor et al., 2018; Yang & Hayes, 2020). The emergence of COVID-19 is therefore highly likely to have exacerbated burnout and distress in psychological practitioners.

Prior to COVID-19, it was already widely acknowledged that psychological practitioners must vigilantly attend to their personal wellbeing as an ethical imperative (Barnett, 2019; Simionato et al., 2019). This is reflected in ethical codes and professional standards, both within the UK and internationally, in which psychological practitioners are required to monitor their wellbeing and intervene should personal issues threaten their professional functioning (American Psychological Association, 2021; European Federation of Psychologists' Associations, 2005; Health & Care Professions Council, 2016; The British Psychological Society, 2017). In response to COVID-19, several professional healthcare organisations have further emphasised the need for staff to pro-actively and pre-emptively attend to their wellbeing by practicing self-care (Academy of Medical Royal Colleges, 2020; British Medical Association, 2020a; British Psychological Society, 2020a; Health & Care Professions Council, 2020; NHS Education for Scotland, 2020; Royal College of Nursing, 2020).

2. Psychological Practitioners' Self-care – Background & Context:

Self-care is notably broadly defined in the professional literature, and can refer to any behaviours and activities that promote health and wellbeing in professional or personal contexts (Rupert & Dorociak, 2019). While this breadth of definition could present challenges to examining and understanding self-care, it nonetheless appears necessary to retain such a wide scope of consideration. Psychological therapists have long been encouraged to cultivate broader self-care strategies, adaptable to their needs and preferences (Norcross, 2000). This aligns with observations that optimal self-care likely depends on the varying characteristics of individual psychological practitioners and their working environments throughout their careers (Coaston, 2017; Dorociak et al., 2017; Zahniser et al., 2017). Recent reviews further support psychological practitioners considering multiple self-care strategies (Jiang et al., 2020; Posluns & Gall, 2019), with many apparently equally effective for a range of psychological professionals during training (Colman et al., 2016). There is therefore increased interest in the precursors to broader self-care uptake, specifically motivational and contextual factors (Jiang et al., 2020; Otto et al., 2019; Sonnentag et al., 2017).

The importance of considering such factors is underlined by observations that psychological practitioners have often chosen not to address their wellbeing or seek support when needed (Bearse et al., 2013; Edwards & Crisp, 2017; Sherman, 1996).



3. Barriers to Psychological Practitioners' Self-care:

Identified barriers to psychological practitioner self-care have previously been categorised into occupational or personal factors (M. F. O'Connor, 2001). Workload pressures have been cited as a prominent occupational barrier to self-care (Bearse et al., 2013; Brownlee, 2016; Edwards & Crisp, 2017; Morris, 2018; Walsh & Cormack, 1994). This corresponds with findings in the wider literature which note workload as the most common job demand implicated in burnout in applied psychologists delivering psychological interventions (McCormack et al., 2018; Westwood et al., 2017) and in the wider mental health workforce (K. O'Connor et al., 2018).

Among the most frequently identified personal factors inhibiting self-care are perceptions of possible stigma and shame (Digiuni et al., 2013; Edwards & Crisp, 2017; El-Ghoroury et al., 2012; Tay et al., 2018). For example fears around "being a client" or being perceived professionally as a "failure" were reported as barriers to seeking support or disclosing/addressing personal difficulties at work by both UK Clinical Psychologists and US Psychotherapists (Cain, 2000; Charlemagne-Odle et al., 2014; Walsh & Cormack, 1994). Early qualitative findings indicate this may remaining the case in the current context, with some psychological practitioners more reluctant to acknowledge distress or seek support due to perceptions that they "should" know how to cope during the COVID-19 pandemic given the nature of their professional training (British Psychological Society, 2020b).

While not directly explored as a barrier to help-seeking in the literature, the stigmatising beliefs and workload pressures previously discussed may be likely to interact with other beliefs and patterns of behaviour found to be prevalent in qualified and trainee psychological practitioners. These include unrelenting standards (e.g. perfectionism, rigid self-expectations regarding performance and responsibility) and self-sacrifice (heightened sensitivity to others' needs, tendency to prioritise others at one's own expense) (Kaeding et al., 2017; Saddichha et al., 2012; Simpson et al., 2019). Qualitative findings support the possibility that these beliefs represent barriers to self-care or adequately responding to burnout in mental health staff, including psychological practitioners (Brownlee, 2016; Charlemagne-Odle et al., 2014; Hammond et al., 2018; Ledingham et al., 2019).

4. Promoting Self-care – The possible role of Motivation:

As well as considering potential barriers to self-care, recent findings from the wider occupational health psychology literature advocate considering motivational factors which may support self-care engagement (Jiang et al., 2020; Otto et al., 2019; Sonnentag et al., 2017).

Interventions derived from Self-determination Theory (SDT) have been found to promote motivation and engagement with multiple health-promoting behaviours across diverse populations/context (Teixeira et al., 2020). SDT differentiates motivation along a continuum ranging from controlled to autonomous (Ryan & Deci, 2017). Health behaviour change appears more effective and lasting when patients experience more autonomous or self-determined motivation to engage in health-promoting behaviours (Ng et al., 2012; Ntoumanis et al., 2020).

The opposite of autonomous (or internally derived) motivation is controlled motivation (externally derived). In health-behaviour change contexts, controlled forms of motivation have at best been found to only briefly increase behavioural engagement, while being accompanied by feelings of anxiety and dissatisfaction (Ng et al., 2012). At worst, controlled forms of motivation have been negatively related to mental/physical health and engagement in health-promoting behaviours (Ng et al., 2012).



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Some support for the application of SDT to the issue of psychological practitioners' self-care can be found in literature findings on burnout in mental health staff, where promotion of staff autonomy is recommended for protecting against burnout (K. O'Connor et al., 2018). Similarly, findings from the wider applied and organisational literature indicate autonomous choice and preference support self-care activities' restorative benefits (Hunter & Wu, 2016; Isoard-Gautheur et al., 2019; Trougakos et al., 2014).

5. Summary:

Psychological practitioners in the current context of COVID-19 are likely to be experiencing increased sources of external regulation to prioritise self-care, including pre-existing professional and ethical obligations, additional prominent and repeated guidance from professional bodies, and an increased need for self-care arising from additional workload demands and resultant increased stress.

SDT would indicate external factors are at best a non-optimal method of motivating individuals to engage in health-promoting behaviours, and may in fact negatively impact motivation as well as psychological well-being. At the same time, based on reviewed evidence, psychological practitioners may well be experiencing internalised drives to either try and meet increasing work demands, prioritise others' needs at the cost of their own, and/or avoid anticipated stigma or negative consequences by avoiding being seen experiencing psychological distress of their own. As SDT would suggest internally derived motivations would more likely predict behaviour, that the internal motivations of many psychological practitioners may be pointing in the opposite direction to self-care is a cause for concern and investigation.

6. RATIONALE FOR STUDY

Proactively enacting self-care strategies is not only an established professional and ethical imperative for psychological practitioners, but is increasingly recommended to support their wellbeing in the current context of the ongoing COVID-19 pandemic. This is important both because they are an at-risk staff population, and because maintaining their wellbeing in turn crucially maximises their ability to provide support to others, at a time when public demand for psychological support is increasing. However, known occupational and personal barriers to self-care exist for psychologists, and are likely to be exacerbated during the COVID-19 pandemic. Further, in combination with the current context, these known barriers threaten to undermine the forms of motivation predicted by SDT to best promote self-care behaviours.

The current research therefore proposes to explore and quantify the potential impact of known barriers on self-care behaviour in practitioner psychologists. This will include occupational barriers (perceived workload) and personal barriers (perceived stigma, maladaptive beliefs regarding high performance and self-sacrifice). Additionally, the present study aims to be the first exploring the potential role of motivation from an SDT perspective, relative to other known factors, in supporting or undermining psychological practitioners' self-care.

It is hypothesised that autonomous motivation, will positively relate to psychological practitioners' enacted self-care behaviours, when controlling for identified barriers (stigma, work demands, the presence of drives towards either self-sacrifice or perfectionism). Further, it is anticipated that each barrier will negatively relate to self-care behaviours and autonomous motivation when other variables are controlled for. Finally, it is anticipated that most psychological practitioners will experience controlled motivation towards self-care.

Greater knowledge of how self-care may be facilitated or impeded for psychological practitioners working within the NHS professional context aligns with the recommendations of the independent review conducted by Stevenson & Farmer (2017), which recommended to the UK government that NHS staff be supported to practice preventative self-care to maintain staff wellbeing. It further aligns with the policy aims of the Scottish Government (2011), to support NHS staff health and wellbeing, in recognition that this in turn improves patient care.



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Appendix I: Sources of Support Document Provided to Survey Respondents.



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PARTICIPANT DEBRIEFING SHEET – SOURCES OF SUPPORT

*Is psychological practitioners' self-care self-determined?
The roles of motivation, workload, stigma, high standards, and self-sacrifice.*

Taking part in this research required participants to reflect on their own approach to self-care, their recent experiences at work, and beliefs/attitudes regarding the self and peers/colleagues. We recognise that doing so has the potential to lead to experiencing discomfort or distress.

In light of this, we have provided a number of possible sources of support below, and would encourage you to review and consider these if you feel support may be helpful at present:

1. If your discomfort/distress relates to workload, working conditions or other occupational matters, we would encourage you to discuss these via established organisational support structures in the first instance. This could include:

- *Clinical or academic supervision*
- *Line management*
- *Student support systems available via your academic institution.*
- *Informal discussions with trusted peers/colleagues.*

2. If the nature of your discomfort/distress means you do not feel able to use the above sources of support, we would recommend you consider the following organisations & resources:

<https://www.nationalwellbeinghub.scot/> - **The National Wellbeing Hub** – Available for any employees of health or social services in Scotland.

<https://www.nhs.uk/mental-health/nhs-voluntary-charity-services/charity-and-voluntary-services/get-help-from-mental-health-helplines/> - **NHS England** has compiled a list of mental health charities, organisations and support groups which can offer expert advice for anyone living in England.

<http://www.wamhinpc.org.uk/mental-health-helplines-links-services-wales/> - **The Wales Mental Health in Primary Care Network** have collated a list of websites and contact numbers for organisations which provide mental health telephone and online advice, support and services for people across Wales.

<https://www.nidirect.gov.uk/articles/mental-health-support> - **NI Direct** (Government Services) has a webpage dedicated to helping people in Northern Ireland find services in their area that can provide the help and support with their mental health.

<https://www.mentalhealthatwork.org.uk/> - **Mind** – This charity, in association with the Royal Foundation and partners, provides advice and support to empower anyone experiencing a mental health problem. Mind has a range of suggestions that could help your wellbeing.



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www.samaritans.org.uk/ - **The Samaritans** provide confidential support for people experiencing feelings of distress or despair.

<https://breathingspace.scot/> - **Breathing Space** - Free, confidential phone and web based service for people in Scotland experiencing low mood, depression or anxiety.

<https://www.bps.org.uk/coronavirus-resources/professional/impact-wellbeing-psychologists> - **The British Psychological Society** has compiled a downloadable document (The impact of Covid-19 on the wellbeing of psychologists) providing guidance and a list of key supports intended to be helpful for practicing psychologists in the current context of COVID-19.

https://acpuk.org.uk/act_webinars/ - **The Association of Clinical Psychologists** provides a weekly ACT-based webinar to support frontline staff working in health and social care and dealing with the impact of Covid-19. Each webinar consisted of an introduction to the principles of Acceptance and Commitment Therapy (ACT), practice examples and opportunities for live interaction with the presenters.

<http://www.dutytocare.info/> - **Duty to Care** – Charity offering an online resource for UK NHS workers providing instant help and support. Can provide access to CBT therapists; Psychotherapists; Mindfulness teachers; Meditation experts; Breath-work experts; Nutritional therapists, Personal trainers, Yoga teachers and Life coaches.

<https://www.beatcovid.co.uk/> - **Beat COVID: Get Prepared** - an online campaign designed to help NHS healthcare workers keep a healthy mind and body during the COVID-19 pandemic. The content is regularly updated and includes mindfulness, home workouts, yoga, sleep tips and nutrition advice, all geared towards quarantine and COVID related issues. Contributors include frontline staff who have kindly volunteered their time, and members of the British Medical Association.

Appendix J: Research Protocol Submitted for Sponsorship by Edinburgh University College of Arts, Humanities and Social Sciences (CAHSS) Research Governance Coordinator.

Is Psychological Practitioners' Self-Care Self-Determined?
Version 2 – 22/09/2021
IRAS ID - 299667

Non-CTIMP Study Protocol

Is psychological practitioners' self-care self-determined? The roles of autonomous motivation, job demands, mental health stigma, self-sacrifice, and perfectionism.

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LIST OF ABBREVIATIONS

ACCORD	Academic and Clinical Central Office for Research & Development - Joint office for The University of Edinburgh and Lothian Health Board
CI	Chief Investigator
CRF	Case Report Form
GCP	Good Clinical Practice
ICH	International Conference on Harmonisation
PI	Principal Investigator
QA	Quality Assurance
REC	Research Ethics Committee
SDT	Self-determination Theory
SOP	Standard Operating Procedure

1 INTRODUCTION

1.1 BACKGROUND

1.1.1 The Wellbeing of Psychological Practitioners – Background and Current Context:

Prior to the emergence of COVID-19, psychological practitioners working in UK health services had been identified as an at-risk professional group, demonstrating general well-being below the national average (Summers, Morris, Bhutani, et al., 2020). A recent survey of 678 UK NHS Clinical Psychologists further found that the percentage of respondents who had previously experienced mental health difficulties (62.7%) exceeded comparable lifetime prevalence of mental health difficulties in the UK general adult population (41%) (Tay et al., 2018). High levels of burnout have also been observed in samples of UK NHS psychological practitioners (J. Johnson et al., 2020; Westwood et al., 2017). This aligns with international literature highlighting burnout as a significant concern in both psychological practitioners and the wider mental health workforce (K. O'Connor et al., 2018; Paris & Hoge, 2010; Simionato & Simpson, 2018).

Following COVID-19, public demand for mental health services has increased, new demands have arisen to expand psychological support within the healthcare workforce, and both demands are projected to rise further (British Medical Association, 2020b; Durcan et al., 2020; Greenberg et al., 2020; Office for National Statistics, 2020; Royal College of Psychiatrists, 2020). Wide-ranging, rapid adjustments to UK mental health services have therefore already been implemented, presenting significant additional challenges for their staff (S. Johnson et al., 2020), including psychological practitioners. A recent survey by the British Psychological Society (BPS), exploring the impacts of COVID-19 on professional psychologists, noted respondents experiencing increased workload demands (incurred by rapid adaption, higher workload, remote working, needing to bring sensitive and potentially traumatic patient work into their homes) and a perceived lack of control and clarity at work (due to shifting guidance, lack of preparedness from services, and personal anxiety/uncertainty) (British Psychological Society, 2020b). In both psychological practitioners and the wider mental health workforce, increased work demands and reduced control/clarity at work have been identified as significant contributors to burnout (K. O'Connor et al., 2018; Yang & Hayes, 2020). The emergence of COVID-19 is therefore highly likely to have exacerbated burnout and distress in psychological practitioners.

A recent review of the literature examining the ethical issues around burnout and distress in psychological practitioners (Simionato et al., 2019) noted burnout as a common feature of unintended professional misconduct, commonly implicated in detrimental impacts to patient well-being and therapeutic progress. This aligns with empirical findings that occupational burnout in UK psychological practitioners was negatively associated with treatment outcomes (Delgadillo et al., 2018).

Prior to COVID-19, it was therefore already widely acknowledged that psychological practitioners must vigilantly attend to their personal wellbeing as an ethical imperative (Barnett, 2019; Simionato et al., 2019). This is reflected in ethical codes and professional standards, both within the UK and internationally, in which psychological practitioners are required to monitor their wellbeing and intervene should personal issues threaten their professional functioning (American Psychological Association, 2021; European Federation of Psychologists' Associations, 2005; Health & Care Professions Council, 2016; The British Psychological Society, 2017). In response to COVID-19, several professional healthcare organisations have further emphasised the need for staff to pro-actively and pre-emptively attend to their wellbeing by practicing self-care (Academy of Medical Royal Colleges, 2020; British Medical Association, 2020a; British Psychological Society, 2020a; Health & Care Professions Council, 2020; NHS Education for Scotland, 2020; Royal College of Nursing, 2020).

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1.1.2 Psychological Practitioners' Self-care – Background & Context:

Self-care is notably broadly defined in the professional literature, and can refer to any behaviours and activities that promote health and wellbeing in professional or personal contexts (Rupert & Dorociak, 2019). While this breadth of definition could present challenges to examining and understanding self-care, it nonetheless appears necessary to retain such a wide scope of consideration. Psychological therapists have long been encouraged to cultivate broader self-care strategies, adaptable to their needs and preferences (Norcross, 2000). This aligns with observations that optimal self-care likely depends on the varying characteristics of individual psychological practitioners and their working environments throughout their careers (Coaston, 2017; Dorociak, Rupert, Bryant, et al., 2017; Zahniser et al., 2017). Recent reviews considering psychological practitioners further support the consideration of multiple self-care strategies (Jiang et al., 2020; Posluns & Gall, 2019), with many apparently equally effective for a range of psychological professionals during training (Colman et al., 2016). There is therefore increased interest in the precursors to broader self-care uptake, specifically motivational and contextual factors (Jiang et al., 2020; Otto et al., 2019; Sonnentag et al., 2017).

The importance of considering such factors is underlined by indications that, for psychological practitioners, an awareness of need alone is not sufficient to enact self-care (W. B. Johnson et al., 2012). Psychological practitioners have often been observed choosing not to address their wellbeing or seek support when needed (Bearse et al., 2013; J. L. Edwards & Crisp, 2017; Sherman, 1996). Further, in the 2019 NHS England staff survey, 51.8% of Clinical Psychologists ($n=5,746$) and 57.2% of Psychotherapists ($n=3,888$) surveyed disclosed they had attended work in the past three months despite not feeling well enough to perform their duties (NHS England, 2019).

1.1.3 Barriers to Psychological Practitioners' Self-care:

1.1.3.1 Occupational Barriers – The Role of Workload:

Identified barriers to psychological practitioner self-care have previously been categorised into occupational or personal factors (M. F. O'Connor, 2001). Workload pressures have been cited as a prominent occupational barrier to self-care. In a sample of UK Clinical Psychologists, 49% reported time pressures prevented them seeking support at work (Walsh & Cormack, 1994). Qualitative observations in UK Clinical Psychologists and Counsellors have

subsequently noted work pressures as the most significant occupational barrier to self-care (Brownlee, 2016; Morris, 2018), a finding replicated empirically and internationally in Australian mental health professionals ($N=98$, 69.2% of which were psychologists) (J. L. Edwards & Crisp, 2017), and American Clinical Psychologists ($N=260$) (Bearse et al., 2013). This corresponds with findings in the wider literature which note workload as the most common job demand implicated in burnout in applied psychologists delivering psychological interventions (McCormack et al., 2018; Westwood et al., 2017) and in the wider mental health workforce (K. O'Connor et al., 2018). Further, difficulty maintaining work-life balance was the factor reported to cause the greatest degree of distress (cited by approximately two-thirds of respondents as being moderately to severely distressing) in an international sample of qualified clinical and counselling psychologists ($N=443$) (Simpson et al., 2019).

1.1.3.2 Personal Barriers – The Role of Stigma:

Among the most frequently identified personal factors inhibiting self-care are perceptions of possible stigma arising due to being a mental health professional seeking support for their own psychological distress. In a survey of 678 UK-based Clinical Psychologists by Tay et al. (2018), participants displayed high levels of perceived stigma (expectations that others will hold or act on negative beliefs or feelings regarding those experiencing mental health difficulties). Further, while two-thirds of participants had experienced mental health problems themselves, more than half experienced reluctance to share this with colleagues and

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superiors. In those who never disclosed their difficulties ($N=46$) over two-thirds cited fear of being judged negatively, or possible negative impacts on their career as barriers to doing so. In those who never sought help ($N=68$), over a third cited the same factors as barriers. Similar results were observed in UK Clinical Psychology trainees, with increasing social stigma found to reduce positive attitudes toward seeking therapy (Digiuni et al., 2013). Similar results were again found by Edwards & Crisp (2017) in their sample of mental health professionals in Australia ($N=98$, 69.2% psychologists), where over two-thirds of respondents reported experiencing feared personal or professional consequences of disclosing or seeking support for personal mental health issues. These included concerns about what co-workers may think, say or do, feelings of embarrassment or shame, fearing being seen as weak, concern about other people they know finding out, and not wishing a mental health problem to be recorded on their medical records (J. L. Edwards & Crisp, 2017). Similar findings were also identified in a USA sample ($N=387$) of predominantly clinical and counselling psychology postgraduate trainees (66.4%) (El-Ghoroury et al., 2012). Reported barriers to the use of wellness promoting strategies included “worry about what could happen” (32.6%) and anticipated shame, guilt or embarrassment (29.6%). These findings also align with the reported experiences of UK Clinical Psychologists and USA Psychotherapists in which perceived stigma and shame, particularly around “being a client” or being perceived as a “failure”, were reported as barriers to seeking support or disclosing/addressing personal difficulties, particularly at work (Cain, 2000; Charlemagne-Odle et al., 2014; Walsh & Cormack, 1994). Early qualitative findings appear to support this remaining the case in the current context, with some psychological practitioners more reluctant to acknowledge distress or seek support due to perceptions that they “should” know how to cope during the COVID-19 pandemic given the nature of their professional training (British Psychological Society, 2020b).

1.1.3.3 The Potential Impact of Maladaptive Schemas:

While not directly explored as a barrier to help-seeking in the literature, the stigmatising beliefs and workload pressures previously discussed may be likely to interact with other maladaptive beliefs and patterns of behaviour (schemas) found to be prevalent in qualified and trainee psychological practitioners. Two such schemas include unrelenting standards (e.g. perfectionism, rigid self-expectations regarding performance and responsibility) and self-sacrifice (heightened sensitivity to others' needs, tendency to prioritise others at one's own expense). In an international sample of qualified clinical and counselling psychologists ($N=443$), a significant proportion of respondents demonstrated unrelenting standards (60% approx.) and self-sacrifice (50% approx.) at levels indicative of clinical significance or pathology (Simpson et al., 2019). These were also the highest endorsed schemas in cross-cultural samples of clinical and counselling psychology trainees (Kaeding et al., 2017; Saddichha et al., 2012). The presence of these internal drives may be further evidenced by an observed disparity between the sources of perceived pressure to attend work, with 94.2% of all NHS England Clinical Psychologists and Psychotherapists surveyed in 2019 ($N=5180$) reporting that they put themselves under pressure to attend work, compared to just 11.8% reporting pressure from co-workers ($N=5168$) and 14.7% from managers ($N=5168$) (NHS England, 2019). Qualitative findings support the possibility that beliefs around unrelenting standards or self-sacrifice further represent barriers to self-care or to adequately responding to burnout in mental health staff, including psychological practitioners (Brownlee, 2016; Charlemagne-Odle et al., 2014; Hammond et al., 2018; Ledingham et al., 2019).

1.1.4 **Promoting Self-care – The possible role of Motivation:**

As well as considering potential barriers to self-care, recent findings from the wider occupational health psychology literature advocate considering motivational factors which may support self-care engagement (Jiang et al., 2020; Otto et al., 2019; Sonnentag et al., 2017). As self-care can refer to any behaviours and activities that promote health and wellbeing (Rupert & Dorociak, 2019), research exploring motivation and health-promoting behaviour changes from the field of health psychology may offer valuable insights.

Interventions derived from Self-determination Theory (SDT) have demonstrated efficacy in promoting motivation and engagement with multiple health-promoting behaviours across diverse populations/contexts (Teixeira et al., 2020). SDT differentiates motivation along a

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continuum ranging from controlled to autonomous (Ryan & Deci, 2017), with health behaviour change appearing more effective and lasting when patients experience more autonomous or self-determined motivation to engage in health-promoting behaviours (Ng et al., 2012; Ntoumanis et al., 2020). Further, enhancing self-determined motivation has been demonstrated to play a key role in enhancing other direct precursors of behaviour including positive attitudes towards target behaviours, perceptions of ability to engage in the target behaviour, with both in turn increasing behavioural intention (Hagger & Chatzisarantis, 2009). The opposite of autonomous (or internally-derived) motivation is controlled motivation (externally-derived).

As an explanatory example, someone autonomously motivated to lose weight may do so because they internally value the perceived health benefits of doing so. In contrast, someone experiencing controlled motivation may lose weight only to avoid punishment (criticism from others for being overweight), secure reward (approval of peers) or avoid feelings of guilt and shame for not exercising. In health-behaviour change contexts, controlled forms of motivation have at best been found to only briefly increase behavioural engagement, while being accompanied by feelings of anxiety and dissatisfaction (Ng et al., 2012). At worst, controlled forms of motivation have been negatively related to mental/physical health and engagement in health-promoting behaviours (Ng et al., 2012). Some support for the application of SDT to the issue of psychological practitioners' self-care can be found in literature findings on burnout in mental health staff, where promotion of staff autonomy is recommended for protecting against burnout (K. O'Connor et al., 2018). Similarly, findings from the wider applied and organisational literature indicate autonomous choice and preference support self-care activities' restorative benefits (Hunter & Wu, 2016; Isoard-Gautheur et al., 2019; Trougakos et al., 2014).

We can therefore hypothetically consider psychological practitioners' motivations to self-care in the current context in terms of SDT's motivational concepts, while also considering previously identified barriers.

1.1.5 Summary:

Psychological practitioners in the current context of COVID-19 are likely to be experiencing increased sources of external regulation to prioritise self-care, including pre-existing professional and ethical obligations, additional prominent and repeated guidance from professional bodies, and an increased need for self-care arising from additional workload demands and resultant increased stress. SDT would indicate external factors are at best a non-optimal method of motivating individuals to engage in health-promoting behaviours, and may in fact negatively impact motivation as well as psychological well-being. At the same time, based on reviewed evidence, psychological practitioners may well be experiencing internalised drives to either try and meet increasing work demands, prioritise others' needs at the cost of their own, and/or avoid anticipated stigma or negative consequences by avoiding being seen to be a psychological professional who is themselves experiencing psychological distress. As SDT would suggest internally-derived motivations would more likely predict behaviour, that the internal motivations of many psychological practitioners may be pointing in the opposite direction of self-care is a cause for concern and investigation.

1.2 RATIONALE FOR STUDY

Proactively enacting self-care strategies is not only an established professional and ethical imperative for psychological practitioners, but is increasingly recommended to support their wellbeing in the current context of the ongoing COVID-19 pandemic. This is important both because they are an at-risk staff population, and because maintaining their wellbeing in turn crucially maximises their ability to provide support to others, at a time when public demand for psychological support is increasing. However, as evidence by the review of literature, known occupational and personal barriers to self-care exist for psychologists, and are likely to be exacerbated during the COVID-19 pandemic. Further, in combination with the current context,

these known barriers threaten to undermine the forms of motivation predicted by SDT to best promote self-care behaviours.

The current research therefore proposes to explore and quantify the potential impact of known barriers on self-care behaviour in practitioner psychologists. This will include occupational barriers (perceived workload) and personal barriers (perceived stigma, maladaptive beliefs regarding high performance and self-sacrifice). Additionally, the present study aims to be the first exploring the potential role of motivation from an SDT perspective, relative to other known factors, in supporting or undermining psychological practitioners' self-care.

It is hypothesised that autonomous motivation, as conceptualised by SDT, will positively relate to psychological practitioners' enacted self-care behaviours, when controlling for identified barriers (stigma, work demands, the presence of drives towards either self-sacrifice or perfectionism). Further, it is anticipated that each barrier will negatively relate to self-care behaviours and autonomous motivation when other variables are controlled for. Finally, it is anticipated that a greater proportion of psychological practitioners' will experience controlled (rather than autonomous) motivation towards self-care.

Greater knowledge of how self-care may be facilitated or impeded for psychological practitioners working within the NHS professional context aligns with the recommendations of the independent review conducted by Stevenson & Farmer (2017), which recommended to the UK government that NHS staff be supported to practice preventative self-care to maintain staff wellbeing. It further aligns with the policy aims of the Scottish Government (2011), to support NHS staff health and wellbeing, in recognition that this in turn improves patient care.

2 STUDY OBJECTIVES

2.1 OBJECTIVES

2.1.1 Primary Objective

- Explore if barriers to self-care identified from the literature independently relate to actual self-care behaviours in psychological practitioners.
- Explore the role of autonomous motivation towards self-care behaviours in psychological practitioners when controlling for potentially confounding demographic variables and identified barriers from the literature.
- Quantify to what extent autonomous motivation, perceived workload, perceptions of role-related stigma, and the presence of drives for either self-sacrifice or meeting excessive performance standards appear to positively or negatively impact the use of self-care behaviours in this staff population.

2.1.2 Secondary Objectives

- Explore to what extent psychological practitioners experience autonomous or controlled motivation towards self-care behaviours?
- Explore the extent to which psychological practitioners report experiencing the barriers to self-care identified from the literature, and if so which barriers appear to be most prevalent/problematic.

- Explore possible interactions and relationships between motivation, and known barriers identified from the literature, which may better explain engagement with self-care behaviours in psychological practitioners.

3 STUDY DESIGN

3.1 DESIGN

A non-experimental, cross-sectional study design will explore relationships between dependent variables (self-care behaviours), and independent variables in two categories: (1) Autonomous motivation towards self-care; (2) Known occupational/personal barriers to self-care (perceived workload, perceptions of role-related stigma, the presence of drives for either self-sacrifice or meeting perfectionistic standards). Data will be gathered via online survey (Qualtrics). This design aims to minimise intrusion/demands for NHS staff in the context of COVID-19, relative to more robust longitudinal approaches, which also present greater complexity and risks to completion within the allocated timeframe.

3.2 SETTING & PARTICIPATION

Pending ethical approval, remote access has been granted to all psychological practitioners (including trainee and qualified Clinical Psychologists, Clinical Associates in Applied Psychology, CBT Therapists, Assistant Psychologists) employed by the student researcher's home health board (NHS Forth Valley). Again, pending ethical approval, remote access has also been granted to all trainees within Edinburgh and Glasgow Universities' respective Clinical Psychology Doctorate courses. It is anticipated that the duration of participant involvement, including reading of promotional information / invitations to participate, completion of the consent process and questionnaire, and reading all provided optional debrief information, will not exceed more than 25 minutes in total, with the consent forms/questionnaire taking less than 15 minutes. Data collection is estimated to commence in October 2021, and conclude by the end of February 2022.

3.3 PROCEDURE

Ethical approval will be sought from the University of Edinburgh. Once confirmed, relevant management (local Head of Service - Psychological Therapies) will be consulted before registering the research with the local health board's Research and Development Office and confirming permission to proceed. Having discussed the proposed research with the local health board's Research and Development Officer, and having consulted relevant guidance, NHS ethical approval is not required for the research as proposed (NHS Health Research Authority, 2020).

Following any amendments necessitated by the university ethics and R&D approval procedures, potential participants will be contacted either via university course administrators or staff wellbeing representatives in psychological services across the participating health board. They will be provided some initial information regarding the research in the form of pre-prepared invitation copy and/or a digital promotional poster provided to the relevant university/health board contacts. They will also be provided with an anonymous web link directing them to complete the research survey via the Qualtrics® online platform. The surveys design and procedure were designed with respect to the following key ethical principles (BPS Research Board, 2017).

3.3.1 Privacy / Withdrawal

A “withdraw” button will be placed at the end of each question block. This will allow participants to indicate their wish to leave the study and have any previously submitted responses deleted at multiple points during the survey. Participant information sheets and pre-survey consent/briefing information will make it clear that withdrawal is only possible during survey completion, and that after final submission withdrawal will no longer be possible. It will be explained that this approach is intended to maximise participant privacy and minimise the potential for participant identification, as providing some option to withdraw later would otherwise necessitate some method of participant identification.

3.3.2 Scientific Integrity

Browser cookies will be enabled to prevent multiple responses from individual participants (with participants being notified of this during the consent process). These cookies will not be stored or accessed by the researchers and will be used only by the Qualtrics survey system. Non-invited responses will be prevented via anonymisation of the survey weblink (which will only be provided to potential participants) and de-indexing the survey from search engines.

Promotional/email copy, survey information/consent text, and the final web survey will be reviewed and amended following piloting and feedback gathered from research supervisors and members of the NHS Forth Valley staff wellbeing steering group.

Participants will be contacted via NHS/university email and provided with a link to the final survey. A maximum of two reminder emails will be sent to minimise intrusion and because no additional gain was found sending more (Cho et al., 2013). The literature does not indicate optimal follow-up timing (Cunningham et al., 2015), so reminders will be sent monthly, coinciding with established staff data collection, and to minimise clashes with academic deadlines. Phased collection can provide improved protection against nonresponse bias (Gosling & Johnson, 2010) via later statistical analysis.

Respondents will be able to contact the lead researcher or field supervisor with any questions before and following participation.

Data will be held at all times during collection, analysis, and after the completion of the project, on secure University of Edinburgh servers.

3.3.3 Data Collected & Measures Proposed:

Demographic information will be gathered via check-boxes, text-entry or drop-down menus in the online survey. Variable selection was limited to potentially confounding variables to maximise respondent anonymity. These include gender, age, years in the profession, and qualification status (prequalified vs qualified) (Bettney, 2017; Dorociak, Rupert, & Zahniser, 2017; El-Ghoroury et al., 2012; Rupert & Kent, 2007), and role-related variables which may impact perceived job demands, including contracted working hours, full/part-time status, percentage of working hours spent in direct client contact vs other non-contact work (e.g. research/admin/academic study), and work setting (urban/rural/mixed).

This study proposes using the following self-report measures. All are either free to use or used with the original authors' permission.

3.3.3.1 The Self-Care Assessment for Psychologists (SCAP):

The SCAP is a 21-item measure assessing domains of self-care behaviour found relevant to the professional and personal functioning of psychologists (Dorociak, Rupert, Bryant, et al., 2017). It contains 5 subscales (Professional Support, Professional Development, Life Balance, Cognitive Awareness, and Daily Balance), and participants reporting the frequency with which they engage in each behaviour on a 7-point Likert scale (1 = "Never", 7 = "Always").

In a developing field with few measures, the SCAP demonstrated among the most robust procedures in both item-generation (using an established conceptual framework), and content evaluation/modification (using expert feedback) (Jiang et al., 2020). Further, practicing psychologists ($N=422$) were used to develop the measure. The SCAP therefore demonstrates high face and content validity. It is also the only extant measure which employed both exploratory and confirmatory factor analysis in demonstrating structural validity (Jiang et al., 2020), and it's factor structure has since been further validated in post-graduate clinical psychology trainees (Zahniser et al., 2017). Finally, the measure consistently demonstrates adequate reliability with Cronbach's alphas for individual subscales ranging almost exclusively between .70 and .83 with one exception ($\alpha = .65$ for cognitive awareness subscale in a trainee sample)(Dorociak, Rupert, Bryant, et al., 2017; Zahniser et al., 2017). These values fall within the most commonly proposed levels of alpha acceptability (Tavakol & Dennick, 2011). Permission for use was provided by the lead author K. Dorociak (personal communication, 8th June 2020).

3.3.3.2 The Comprehensive Relative Autonomy Index (C-RAI):

The C-RAI (Sheldon et al., 2017) was developed as a means of confirming the relative autonomy continuum proposed by self-determination theory (SDT). 24-items describe distinct motives for engaging with a target behaviour (e.g "because I enjoy doing X"). Respondents rate their agreement on a scale of 1 (Strongly disagree) to 5 (Strongly agree). The items form 6 subscales capturing distinct and increasingly autonomous forms of motivation. A total score representing relative-autonomy towards a target behaviour (presently self-care) is generated by combining individual subscale scores.

This measure is proposed for three reasons. First, it is designed specifically for adaption to new target behaviours, required presently to measure a previously-unexplored concept (self-care motivation). Secondly, it incorporates a factor structure and common, semantically-invariant item stems which have been previously and extensively validated (Howard et al., 2017; Sheldon et al., 2017), conferring construct and content validity. Reliability was also assessed across 4 international samples (total $N=958$)(Sheldon et al., 2017), with Cronbach's alpha values for all subscales between .71 to .94 apart from in two instances (minimum .61) indicating acceptability. Finally, the measure's ability to capture amotivation allows it to simultaneously account for psychologists' previously reported tendency to intentionally or subconsciously ignore their own self-care needs.

Relative-autonomy measures have received criticism, noting additional insight is gained by considering each distinct SDT motivational sub-type (Howard et al., 2018). However, the C-RAI will still enable more detailed exploration. While using 6 motivational predictors as opposed to one would limit statistical power in this initial exploratory study, descriptive data

from the 6 subscales will be used to determine if specific motivational states appear worthy of additional exploratory post-hoc statistical analysis.

Permission for use was provided by the lead author K.M. Sheldon (personal communication, 24th July 2020).

3.3.3.3 The Health and Safety Executive Management Standards Indicator Tool (HSEMS-IT):

Occupational demands will be measured using the 8 items comprising the “Demands” subscale of the HSEMS-IT (Health and Safety Executive, 2020). Respondents report how frequently they experience workplace demands using a 7-point Likert scale (1 = “Never”, 7 = “Always”). The measure arose from extensive theoretical research and widespread UK public consultation, consequently demonstrating high content and face validity (Cousins et al., 2004; MacKay et al., 2004). Its factorial validity was confirmed during development (Cousins et al., 2004) ($N=3147$) and subsequently by further large-scale confirmatory factor analyses ($N=26,382$ and $N=67,347$) in UK public-sector samples which included substantial proportions of NHS services (between 26% and 38% of respondents) (J. A. Edwards et al., 2008; J. A. Edwards & Webster, 2012). It has demonstrated good construct and concurrent validity, relating predominantly in the expected fashions with psychological wellbeing, job satisfaction and performance (Brookes et al., 2013; Houdmont et al., 2013), including in healthcare staff and psychological practitioners (Kerr et al., 2009; Summers, Morris, & Bhutani, 2020). Finally, the demand subscale demonstrated acceptable Cronbach's alpha reliabilities of between .84 to .89 across several large-scale studies (Cousins et al., 2004; J. A. Edwards et al., 2008; J. A. Edwards & Webster, 2012; Houdmont et al., 2013).

3.3.3.4 The Almost Perfect Scale-Revised (Short-form)(SAPS):

This measure is intended to capture the presence of unrelenting high standards. Based on previous work by Slaney et al. (2001), the SAPS includes two subscales (“Standards” and “Discrepancy”) containing 4 items each, respectively assessing the presence of high performance standards, and self-critical/negative evaluations of personal performance (Rice et al., 2014). Participants rate their agreement with each item on a 7-point Likert scale (1 = “Strongly Disagree”. 7 = “Strongly Agree”). Subscale scores are combined to give a global score for perfectionism.

The factorial validity of the original measure on which the short-form was based was confirmed in multiple exploratory and confirmatory factor analyses, with both the standards and subscale scores routinely demonstrating concurrent validity relating to measures of wellbeing and personality (Rice et al., 2014). The factor structure was replicated during SAPS development, and cross-culturally via subsequent confirmatory factor analysis (Wang et al., 2016). The SAPS also demonstrated criterion, convergent and discriminant validity during development (Rice et al., 2014), with additional criterion validity demonstrated since, relating with both self-report and physiological measures (Moroz & Dunkley, 2019; Perrone-McGovern et al., 2017; Richardson et al., 2014). Reported Cronbach's alpha scores for the Standards (.86 to .89) and Discrepancy (.84 to .88) SAPS subscales indicate acceptable reliability (Perrone-McGovern et al., 2017; Rice et al., 2014; Richardson et al., 2014).

3.3.3.5 The Revised Unmitigated Communion Scale (UCS-R):

This measure is intended to capture beliefs and tendencies towards self-sacrifice, as Unmitigated Communion describes a focus on others while neglecting the self (Fritz & Helgeson, 1998). Previously created for use in cardiac patients, the scale was revised to be generalisable to wider populations (Fritz & Helgeson, 1998). During development the measure demonstrated adequate Cronbach's alpha reliability (ranging between .7 to .8) as well as high test-retest reliability (Fritz & Helgeson, 1998). While the majority of subsequent studies involve undergraduate participants or those with specific health conditions, the measure has subsequently further demonstrated adequate reliability (Cronbach's alpha .81) in a more relevant population of helping professionals (German Occupational Therapists)(Jacobs et al., 2015). Convergent validity of relevance to the proposed research include observed positive relationships with psychological distress and enacted supportive behaviours (Helgeson & Fritz, 1999; Jacobs et al., 2015; Jin et al., 2010), and negative relationships with health-promoting behaviours relevant to self-care (including diet, exercise, relaxation)(Helgeson & Fritz, 1999). Permission for use was provided by the lead author V.S. Helgeson (personal communication, 14th March 2021).

3.3.3.6 Mental Health Professional Stigma Scale (MHPSS):

The MHPSS assesses stigmatising beliefs and attitudes held by mental health professionals regarding occupational stress and burnout (Clough et al., 2020), across four domains. Structural stigma and perceived other stigma describe the respondents' anticipated reactions from general co-workers and fellow mental health professionals respectively were they to disclose occupational stress/burnout. Self-stigma captures respondents' belief they should self-sufficiently manage personal distress, while personal stigma captures attitudes held towards other distressed mental health professionals. Participants rate agreement with items on a 7-point Likert scale (1 = "Strongly Disagree". 7 = "Strongly Agree"). Subscale items are summed to create a total score.

The scale's theoretical basis and factorial validity was developed from a similar measure for medical professionals (Clough et al., 2019), with potential limitations noted. Both utilised small samples, initial item pools, limited expert review of included items, and exploratory rather than confirmatory factor analysis. However, assessment of these factors against established guidance for assessing methodological quality in measure development indicated measures taken would nonetheless constitute "very good" or "adequate" practice (Mokkink, 2018; Mokkink et al., 2010). Further, the MHPSS has demonstrated initial convergent and divergent validity, and full-scale Cronbach's alpha reliability of .84, indicating acceptability (Clough et al., 2020).

Completion time for the full survey, utilising the measures proposed above and based on a tested draft further analysed by Qualtrics®, is less than 10 minutes, indicating low participant burden (Qualtrics®, 2020).

Finally, to respectively minimise risks from response bias and low-effort responding, where measures do not indicate specified orders (e.g. C-RAI), items will be randomised (Meade & Craig, 2012).

4 STUDY POPULATION

4.1 NUMBER OF PARTICIPANTS

A priori power calculations determined a minimum sample requirement of $N=92$ would be required for the proposed research and analysis. (5 experimental independent variables, 15 control covariates including demographic items or potential confounders). The maximum possible responses, assuming a 100% response rate in the intended samples would equate to approximately 270 participants who could meet the proposed inclusion criteria. This represents approximately 90 potential participants each from NHS Forth Valley and Edinburgh/Glasgow Universities' respective Clinical Doctorate Courses.

Estimated total recruitment time will overlap with the data collection period (as recruitment merely involves the sending and promotion of the online survey link), and so will last for an anticipated maximum of four months.

The study will take place at a single research site (The University of Edinburgh) though participants will complete the online form remotely from various sites across the country.

4.2 INCLUSION CRITERIA

(All must be met)

1. Participants must be currently employed both:
 - a. By a UK-based health or social care organisation, in either the statutory or third sector.
 - b. As a psychological practitioner in a regulated qualified or pre-qualification role (Doctor of Clinical Psychology, Counselling Psychologist, Other Qualified/Accredited Psychotherapist, Psychological Wellbeing Practitioner, Primary Care Mental Health Worker, Assistant Psychologist, Trainee Clinical Psychologist, Trainee Clinical Associate in Applied Psychology).
2. Participants must have been working in one or some combination of the aforementioned roles for at least the past 2 months (with no significant recent absences if new in the role).
3. Participants must be able to communicate in English (psychometric measures proposed have not undergone multilingual validation).
4. Participant must have normal vision (or corrected to normal vision with the use of visual aids e.g. glasses, contact lenses).

4.3 EXCLUSION CRITERIA

1. Individuals working solely in private practice (as the organisational context and role demands cannot be adequately presumed or ascertained).

5 PARTICIPANT SELECTION AND ENROLMENT

5.1 IDENTIFYING PARTICIPANTS

Participants will be identified by their being either (a) Currently employed as a psychological practitioner in NHS Forth Valley; (b) Currently enrolled in either the Edinburgh or Glasgow University doctoral programmes in Clinical Psychology.

In NHS Forth Valley, a psychological therapies staff wellbeing steering group exists which collects staff data by monthly electronic survey and promotes its completion within teams. This group has approved the researcher sharing/promoting their proposed online survey via this established route in order to approach potential participants. Participation and informed consent will be further supported by the lead researcher offering to speak at all departmental team meetings, as staff wellbeing is a service-wide standing agenda item. Participation from within the two doctoral programmes will be promoted via emails from respective course administrators, with the lead researcher's contact information provided to facilitate enquiry and support recruitment.

Should these routes fail to recruit the required number of participants, additional recruitment methods may be deployed. These include recruitment utilising the same methods as described previously, in which contact will be made and invitations for participation will be extended via other educational organisations and professional organisations which work with or represent trainee or qualified psychological practitioners. Examples may include, but are not limited to, The Universities of Dundee and Stirling (both of which administer training programme for Clinical Associates in Applied Psychology), Caledonian University (which administers a doctoral training programme in Counselling Psychology), course centres providing accredited qualifications in CBT, and professional organisations (e.g. British Psychological Society or The British Association for Behavioural & Cognitive Psychotherapies). Should these routes also fail participation will be invited via advertisement on social media platforms and relevant professional message boards for psychological practitioners (e.g. psychological practitioner Facebook groups). Further, peers and colleagues of the researchers, and NHS staff comprising the local psychological services staff wellbeing representatives, will share invitations to participate among their relevant professional contacts, and encourage these to be snowballed onwards.

5.2 CONSENTING PARTICIPANTS

5.2.1 Valid Consent

Prior to being directed via link to the online survey, promotional information will provide an overview of the proposed research to support informed consent. If choosing to participate, an information page will start the online Qualtrics survey, expanding on prior information received by participants, outlining all information recommended by relevant ethical guidance to ensure consent (BPS, 2014). Including:

- Identify of the data controller (The University of Edinburgh, represented by the lead researcher)
- Sufficient information to enable participants to understand the project is examining and what is required of them.

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- Any possible risks arising from participation and where required steps taken to minimise this risk.
- Consent to participate in the research.
- The legal basis on which the research is lawful.
- Contact information in the event of more information being required (researchers' contact details), an independent contact for complaints, and the contact details of the University of Edinburgh's Data Protection Officer (dpo@ed.ac.uk)
- Details of how participants can exercise their rights (right to opt-out of research right to withdrawal within specified time-frame).
- Information assuring how their data will be securely held.
- An explanation that if the research project changes in any way, the amended patient information sheet will be made available via the same methods used for recruitment.

This page will also be made available as a downloadable PDF sent out with the original invitation and available to download prior to participation for potential participants own records. Participants will be able to take as long as they wish to review/consider the above before choosing to participate. Explicit consent/debrief statements will bookend the survey, broken into subsections requiring check-box approval, to maximise readability and confirm understanding of each key aspect of participation.

5.2.2 Withdrawal of Study Participants

As previously outlined, A "withdraw" button on the online survey will allow participants to indicate their wish to leave the survey and have their responses deleted. Participants will therefore be free to withdraw from the study at any point during participation. If withdrawal occurs, a text entry box will be provided to participants so they can if they choose anonymously explain their primary reasons for withdrawal.

6 STUDY ASSESSMENTS

6.1 STUDY ASSESSMENTS

Assessment	Screening / Recruitment	Day 1 (Survey Completion)
Assessment of Eligibility Criteria	☒	
Written informed consent		☒
Demographic data & Questionnaire		☒

7 DATA COLLECTION

Data will be collected at a single time point (participants' completion of the online survey) by the lead field researcher / named student only (Alistair Merrick, Trainee Clinical Psychologist).

As previously described the questionnaire will utilise a combination of demographic items and standardised measures. Missing data will be prevented by designing the online survey to require completion of each item on each section before proceeding. A maximum of two email reminders for completion will be sent to each participating organisation to support data gathering.

8 DATA MANAGEMENT

8.1 PERSONAL DATA

Response data relating to experimental variables of interest will not constitute personal data as they report non-unique attitudes/behaviours. There is a very limited possibility that demographic items obtained, in combination or alongside other information available to the researchers (from working in the same health board/university where data is being gathered) may enable identification. These demographic variables are therefore listed below as potentially constituting personal data in the context of the research proposed:

- Gender
- Age
- Years in the profession.
- Qualification status (qualified vs. trainee).
- Contracted working hours.
- Full/part-time status.
- Percentage of working hours spent in direct client contact vs other non-contact work (e.g. research/admin/academic study).
- Work setting (urban/rural/mixed).

No name, job title or other identifying contact information will be gathered, and thus each participants' responses will be as fully anonymised as possible.

All data, including the potential personal data outlined above, will be stored on secure University of Edinburgh data servers, initially as raw response data in the named student's Qualtrics account, and then in password-protected Excel or SPSS files stored within the named student's university Onedrive account. This data will be primarily accessed by the named student only. Access to this data will only be granted to other named researchers and will be limited to the minimum access to data required to assist with specified aspects of analysis.

The named student will keep a record of all data handling throughout the project. All data retained will be stored until no longer required and for a maximum of ten years, after which time the data shall be permanently destroyed in line with university guidelines for data retention.

8.2 DATA INFORMATION FLOW

Any potential personal data outlined previously will be gathered via online questionnaire and stored on University of Edinburgh secure Qualtrics servers. Once data collection is complete, data will be exported to the named student's university Onedrive storage as new digital file types (e.g. XSLX format for MS Excel, or SPSS file format) to enable statistical analysis.

8.3 TRANSFER OF DATA

Data collected or generated by the study (including potential personal data) will not be transferred to any external individuals or organisations outside of the Sponsoring organisation(s). Upon completion of the named student's university studies, data will be securely electronically transferred to the named academic supervisor.

8.4 DATA CONTROLLER

The University of Edinburgh is the data controller along with any other entities involved in delivering the study that may be a data controller in accordance with applicable laws (e.g. the site).

8.5 DATA BREACHES

Any data breaches will be reported to the University of Edinburgh Data Protection Officer who will onward report to the relevant authority according to the appropriate timelines if required.

9 STATISTICS AND DATA ANALYSIS

9.1 SAMPLE SIZE CALCULATION

Multiple linear regression will compare independent variables' (IVs) contributions to the dependent variables (DV) of self-care behaviours, while holding constant other IVs' effects (Tabachnick & Fidell, 2014). As the proposed research is novel in comparing the selected variables, existing research cannot inform a priori power analysis. Assumptions were therefore made seeking to balance ability to detect observable effects (power), and the practical utility of effect sizes observed (Tabachnick & Fidell, 2014). As anything below a medium effect size is likely of low utility in clinical psychological research (Barker et al., 2016), this was chosen as the target minimum observable effect size. For the conventionally proposed power of .80, this would indicate an effect size of $f^2 = .15$ (as derived from the squared partial correlation coefficient, R^2) (Cohen, 1988, 1992).

The most prominently reported heuristic approach to sample size estimation for regression analysis is that of Green (1991). However, a recent study found Green's heuristically-derived sample sizes represented a significant overestimation in conditions similar to that proposed by this study (regression models with few experimental IVs) (Dattalo, 2018). It was consequently recommended G*Power (Erdfeider et al., 2009) be used to derive sample size estimates to optimally balance power, precision (in terms of confidence intervals) and practicality.

As the research intends to identify predictor variables' impacts rather than regression model significance, a medium effect size would be indicated by a minimum squared partial correlation value of interest of $R^2 = .13$ (Dattalo, 2008). To observe this effect, based on an alpha error probability of .05 (Cohen, 1988), statistical power of .80, with 5 tested IVs, and up to 15 additional non-tested control covariates, G*Power indicates a minimum sample requirement of $N=92$.

Rounding down to the nearest ten to remain conservative, 90 staff are accessible in the lead researcher's health board. Monthly survey data currently secures an average 67% completion rate. Rounding down similarly, 180 trainees will be accessible by email. Assuming a rounded-

down 60% response rate from within the health board, securing 54 participants, leaving 36 trainees (or 20%) required.

Postal response rates range from 29.5% in qualified USA-based psychologists (Dorociak, Rupert, & Zahniser, 2017), to between 41% and 42.2% in UK-based trainees (Kumary & Baker, 2008; Palomo et al., 2010). When self-reporting on a more emotive topic (vicarious trauma) than that proposed by this research, response rates remained within this range in UK trainees online (33.3%)(Makadia et al., 2017) and USA trainees by post USA (36.3%)(Adams & Riggs, 2008). Even considering online surveys lag other formats' response rates by 12 percentage points on average (Daikeler & Bo, 2020), an estimated response range of 17.5-30.2% would therefore appear achievable.

Finally, if the above response target appears unachievable, contingencies can be deployed to increase participation (see **5.1 – Identifying Participants**).

9.2 PROPOSED ANALYSES

Data will be analysed using IBM SPSS v.25, Microsoft Excel, R (R Core Team, 2013), or equivalent software as required.

9.2.1 Data Quality

Data accuracy and missing data (Tabachnick & Fidell, 2014) will be largely prevented using online methodology. Survey progression and submission will only be permitted if all items are completed, with responses only possible within specified options/ranges. Proofreading will however ensure accuracy during data analysis.

Low-effort responses will be identified and excluded in line with Meade & Craig's (2012) recommendations, by examining response times, and consecutive identical responses. Wave analysis (as described by Phillips et al., 2016) will assess self-selection bias (Eysenbach & Wyatt, 2002), comparing initial responders' data to responses only received after reminders to participate.

Data inspection will identify potential outliers and ensure assumptions of normality, linearity, and homoscedasticity required for multiple regression procedures are met. Necessary adjustments (e.g. data transformations) will be completed in line with recommendations as outlined by Tabachnick & Fidell (2014) and wider literature as required.

9.2.2 Data Analysis

Descriptive data (e.g. item response frequencies, mean values, standard deviations and ranges) will be examined for all variables to assist data interpretation, and ensure sample demographics align with those of the wider workforce, implying generalisability. C-RAI subscale data will be used to address hypothesis 3.

Univariate correlation analysis will first explore potential relationships between all independent, dependent, and demographic/control variables (see **Table 1**). This will highlight potential multicollinearity issues in the proposed regression models (see below) and address hypothesis 4.

Five multiple linear regression models will be constructed using each of the five self-care behavioural subdomains outlined in the SCAP as distinct dependent variables (see **Table 1**). All models will include the five aforementioned experimental independent variables as tested predictors and all proposed demographic variables as non-experimental control covariates (see **Table 1**).

A sixth regression model will be created to further address hypothesis 4. In this model C-RAI scores for autonomous motivation towards self-care will become the dependent variable, with all remaining independent and demographic/control variables listed in **Table 1** included as before.

9.2.3 Table 1: Proposed Dependent/Independent Variables and Control Covariates:

<u>Dependent Variables (and measures used):</u>	<u>Independent Variables (and measures used):</u>	<u>Demographic / Control Variables:</u>
Self-Care Behaviour Domain (SCAP) - Professional Support - Professional Development - Life Balance - Cognitive Awareness - Daily Balance	- Autonomous motivation towards self-care (C-RAI). - Work demands (HSEMS-IT). - Stigma (beliefs/attitudes regarding occupational stress and burnout in mental health professionals) (MHPSS). - Unrelenting performance standards / perfectionism (SAPS). - Self-sacrifice (UCS-R)	- Gender - Age - Years in the profession. - Qualification status (qualified vs. trainee). - Contracted working hours. - Full/part-time status. - Percentage of working hours spent in direct client contact vs other non-contact work (e.g. research/admin/academic study). - Work setting (urban/rural/mixed). (All gathered via dedicated Qualtrics Survey Items).

The high number of control covariates are included in the model as power analysis affords this, but also because reducing covariates through selection can compromise model stability, the unbiasedness of regression coefficients, and p-value/confidence interval validity when conducting explanatory modelling (Heinze et al., 2018). Hypotheses 3 and 4 will be addressed by examining each model's regression coefficients.

Statistical significance will be assessed following adjustment for multiple comparisons using the Holm-Bonferroni procedure (Holm, 1979), maintaining a familywise error rate of 0.05. This method is effective at preventing type-1 error, but with increased power and reduced type-2 error risk (Ludbrook, 1998; Stevens et al., 2017).

9.2.4 Exploratory Analysis

While the sample size achievable by this research is likely to limit statistical power, considering ethical imperatives to maximise research benefits (BPS, 2014), additional exploratory analysis will aim to further contextualise results and inform future research.

As the C-RAI will be customised for use in this study, and its factor structure is untested in this population/context, confirmatory factor analysis (CFA) will assess possible test bias and examine if underlying motivational constructs can be generalised to this sample (Brown, 2015). Univariate correlational analysis between C-RAI and SCAP subdomain scores will also enable consideration of the C-RAI's convergent validity.

Canonical correlation analyses (Thompson, 2005) will be conducted considering all IVs and DVs simultaneously to better indicate which factors alone or in combination relate to the greatest differences in overall self-care behaviours. If the obtained sample exceeds size expectations, analyses could potentially utilise individual IV subdomains, allowing more detailed examination of the relative contribution of each factor (e.g. motivational sub-type) towards self-care. Findings at this stage, in combination with primary results and literature guidance, could inform a final stage of exploratory path analysis to visually clarify relationships between identified key variables (Loehlin, 2004).

10 RISKS

Consider risk level for this study: even if a non-CTIMP, should the protocol still provide details of how adverse events, etc., will be dealt with / reported? Please contact ACCORD for further advice.

The research will require participants' to reflect on their approach to self-care and a number of aspects of their working practice including beliefs/attitudes regarding themselves and peers/colleagues. Self-reflection inherently involves the potential for both positive and negative self-evaluation, which could result in participants' consequently experiencing positive or negative affect.

However, self-awareness and reflective practice are recognised as core competencies for psychological practitioners in training and beyond (The British Psychological Society, 2019). Further, professional practice guidelines note the importance of psychological practitioners attending to and maintaining their own well-being, considering their own self-care (The British Psychological Society, 2017). It is therefore highly likely that intended participants will already have reflected on at least some of the topics raised by the proposed research as part of their routine practice. Pre-qualified participants will also at minimum be developing experience in successfully self-managing their own reflections on their professional practice. The risk of this research inducing additional psychological stress or discomfort via self-reflection would therefore be judged as low. Nonetheless, to further minimise risk to participants, the following measures are proposed:

1. As part of the consent procedure for the online survey, prior to participation individuals will be informed of the specific topics they will be asked to reflect on. They will also be reminded that such reflection has the potential to induce positive or negative self-evaluation, and consequent stress or discomfort. Participants will therefore be better able to evaluate their own risk of distress and whether or not to proceed.
2. Debriefing material provided to participants at the end of the survey will provide context for each topic discussed in the survey in terms of findings from the scientific literature. For example, it will emphasise that workload demands are a common source of distress in psychological practitioners, that it is common for psychological

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practitioners to hold themselves to high standards of personal accomplishment (in turn leading to distress), and for psychological practitioners to experience barriers towards self-care. This will hopefully contextualise participants' experiences in a way which validates participant's experiences, minimizes the chances of negative self-evaluation, and thus reduces their risks of psychological distress or discomfort.

3. Up-to-date links and recommendations regarding relevant sources of support will be provided to all participants as part of the debriefing information. These will include recommendations to discuss any work-related issues arising via established routes of supervision (supervisors/line managers) and potentially trusted peers as appropriate. Links to current sources of support for psychological distress and discomfort (e.g. The National Wellbeing Hub, Breathing Space etc) will also be included. This will offer participants a range of options for varied eventualities.
4. In line with ACCORD guidance, participant information sheets will include details for a relevant contact within the University of Edinburgh for filing any complaints arising relating to the research proposed.

11 OVERSIGHT ARRANGEMENTS

11.1 INSPECTION OF RECORDS

Investigators and institutions involved in the study will permit trial related monitoring and audits on behalf of the sponsor, REC review, and regulatory inspection(s). In the event of audit or monitoring, the Investigator agrees to allow the representatives of the sponsor direct access to all study records and source documentation. In the event of regulatory inspection, the Investigator agrees to allow inspectors direct access to all study records and source documentation.

11.2 STUDY MONITORING AND AUDIT

The ACCORD Sponsor Representative will assess the study to determine if an independent risk assessment is required. If required, the independent risk assessment will be carried out by the ACCORD Quality Assurance Group to determine if an audit should be performed before/during/after the study and, if so, at what frequency.

Risk assessment, if required, will determine if audit by the ACCORD QA group is required. Should audit be required, details will be captured in an audit plan. Audit of Investigator sites, study management activities and study collaborative units, facilities and 3rd parties may be performed.

The study shall also be monitored on an ongoing basis by both academic and clinical supervisors named. This shall ensure that the proposed research is conducted in line with this protocol, and at all stages completed within the pre-agreed timeframe as outlined in the student's original research proposal. Records of supervision regarding the project are also noted by the named student on an ongoing basis, with a record of all meetings logged on the University of Edinburgh Learn space.

12 GOOD CLINICAL PRACTICE

12.1 ETHICAL CONDUCT

The study will be conducted in accordance with the principles of the International Conference on Harmonisation Tripartite Guideline for Good Clinical Practice (ICH GCP).

Before the study can commence, all required approvals will be obtained and any conditions of approvals will be met. These will include ethical scrutiny at various stages of the research process including academic feedback from the original research proposal submitted, approval of the University ethics committee, approval of the local NHS Forth Valley board Research and Development officer, and academic assessment and scrutiny of the completed thesis project.

12.2 INVESTIGATOR RESPONSIBILITIES

The Investigator is responsible for the overall conduct of the study at the site and compliance with the protocol and any protocol amendments. In accordance with the principles of ICH GCP, the following areas listed in this section are also the responsibility of the Investigator. Responsibilities may be delegated to an appropriate member of study site staff.

12.2.1 Informed Consent

The Investigator is responsible for ensuring informed consent is obtained before any protocol specific procedures are carried out. The decision of a participant to participate in research is voluntary and should be based on a clear understanding of what is involved.

Participants will receive adequate written information – appropriate Participant Information and Informed Consent documentation will be provided. Additional oral explanation to the participant will be available on request, either via attendance at NHS/University meetings to discuss the proposed research, or more directly via the provision of contact information for the named student and academic supervisor. Upon request all elements specified in the Participant Information Sheet and Consent documentation can be discussed further.

The participant will therefore be given every opportunity to clarify any points they do not understand and, if necessary, ask for more information. The participant will be given sufficient time to consider the information provided as there is no time limit on participation and no set

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time specified for reading of the participant information or consent documentation. It will be emphasised that the participant may withdraw their consent to participate at any time throughout their completion of the online survey.

12.2.2 Study Site Staff

The Investigator will ensure familiarity with the protocol and the study requirements. The investigator shall additionally ensure that all staff assisting with the study are adequately informed about the protocol and their related duties.

12.2.3 Data Recording

The Principal Investigator is responsible for the quality of the data recorded at each Investigator Site.

12.2.4 GCP Training

For non-CTIMP (i.e. non-drug) studies all researchers are encouraged to undertake GCP training in order to understand the principles of GCP. However, this is not a mandatory requirement unless deemed so by the sponsor. GCP training status for all investigators will be indicated in their respective CVs.

12.2.5 Confidentiality

All evaluation forms, reports, and other records must be identified in a manner designed to maintain participant confidentiality. All records must be kept in a secure storage area with limited access. Clinical information will not be released without the written permission of the participant. The Investigator and study site staff involved with this study may not disclose or use for any purpose other than performance of the study, any data, record, or other unpublished information, which is confidential or identifiable, and has been disclosed to those individuals for the purpose of the study. Prior written agreement from the sponsor or its designee must be obtained for the disclosure of any said confidential information to other parties.

12.2.6 Data Protection

All Investigators and study site staff involved with this study must comply with the requirements of the appropriate data protection legislation (including the General Data Protection Regulation and Data Protection Act) with regard to the collection, storage, processing and disclosure of personal information.

Computers used to collate the data will have limited access measures via user names and passwords.

Published results will not contain any personal data and will be of a form where individuals are not identified and re-identification is not possible.

STUDY CONDUCT RESPONSIBILITIES

12.3 PROTOCOL AMENDMENTS

Any changes in research activity, except those necessary to remove an apparent, immediate hazard to the participant in the case of an urgent safety measure, must be reviewed and approved by the Chief Investigator.

Amendments will be submitted to a sponsor representative for review and authorisation before being submitted in writing to the appropriate REC, and local R&D for approval prior to participants being enrolled into an amended protocol.

12.4 MANAGEMENT OF PROTOCOL NON COMPLIANCE

Prospective protocol deviations, i.e. protocol waivers, will not be approved by the sponsors and therefore will not be implemented, except where necessary to eliminate an immediate hazard to study participants. If this necessitates a subsequent protocol amendment, this should be submitted to the REC, and local R&D for review and approval if appropriate.

Protocol deviations will be recorded in a protocol deviation log and logs will be submitted to the sponsors every 3 months. Each protocol violation will be reported to the sponsor within 3 days of becoming aware of the violation. All protocol deviation logs and violation forms should be emailed to QA@accord.scot

Deviations and violations are non-compliance events discovered after the event has occurred. Deviation logs will be maintained for each site in multi-centre studies. An alternative frequency of deviation log submission to the sponsors may be agreed in writing with the sponsors.

12.5 SERIOUS BREACH REQUIREMENTS

A serious breach is a breach which is likely to effect to a significant degree:

- (a) the safety or physical or mental integrity of the participants of the trial; or
- (b) the scientific value of the trial.

If a potential serious breach is identified by the Chief investigator, Principal Investigator or delegates, the sponsor (seriousbreach@accord.scot) must be notified within 24 hours. It is the responsibility of the co-sponsors to assess the impact of the breach on the scientific value of the trial, to determine whether the incident constitutes a serious breach and report to research ethics committees as necessary.

12.6 STUDY RECORD RETENTION

All study documentation will be kept for a minimum of 10 years from the protocol defined end of study point. When the minimum retention period has elapsed, study documentation will not be destroyed without permission from the sponsor.

12.7 END OF STUDY

The end of study is defined as the last participant's last visit.

The Investigators or the sponsor have the right at any time to terminate the study for clinical or administrative reasons.

The end of the study will be reported to the REC, and R+D Office(s) and sponsor within 90 days, or 15 days if the study is terminated prematurely. The Investigators will inform participants of the premature study closure and ensure that the appropriate follow up is arranged for all participants involved. End of study notification will be reported to the co-sponsors via email to resgov@accord.scot

A summary report of the study will be provided to the REC within 1 year of the end of the study.

12.8 INSURANCE AND INDEMNITY

The co-sponsors are responsible for ensuring proper provision has been made for insurance or indemnity to cover their liability and the liability of the Chief Investigator and staff.

The following arrangements are in place to fulfil the sponsors' responsibilities:

- The Protocol has been designed by the Chief Investigator and researchers employed by the University and collaborators. The University has insurance in place (which includes no-fault compensation) for negligent harm caused by poor protocol design by the Chief Investigator and researchers employed by the University.
- Sites participating in the study will be liable for clinical negligence and other negligent harm to individuals taking part in the study and covered by the duty of care owed to them by the sites concerned. The sponsor requires individual sites participating in the study to arrange for their own insurance or indemnity in respect of these liabilities.
- Sites which are part of the United Kingdom's National Health Service will have the benefit of NHS Indemnity.
- Sites out with the United Kingdom will be responsible for arranging their own indemnity or insurance for their participation in the study, as well as for compliance with local law applicable to their participation in the study.

13 REPORTING, PUBLICATIONS AND NOTIFICATION OF RESULTS

13.1 AUTHORSHIP POLICY

Ownership of the data arising from this study resides with the study team – Alistair Merrick, Dr Mark Hoelterhoff, Dr. Martha Gillespie, and Dr Susan Ramsay.

14 REFERENCES

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Appendix K: Confirmation of Sponsorship by Edinburgh University College of Arts, Humanities and Social Sciences (CAHSS) Research Governance Coordinator.



Template Version No: 1.6

Study Information

1. * IRAS Project ID	299667
2. * Full Title of the Study	Is psychological practitioners' self-care self-determined? The roles of autonomous motivation, job demands, mental health stigma, self-sacrifice, and perfectionism.
3. * Legal Name(s) of Sponsor/Co-Sponsors/Joint-Sponsors	University of Edinburgh
4. Contact details of person acting on behalf of Sponsor for questions relating to study set up. Please enter details of the person who is the Sponsor's main point of contact for all correspondence on setting up the study at this NHS / HSC organisation. This contact may be the Sponsor, a Study Manager, Clinical Research Scientist or Study Coordinator. Where a Contract Research Organisation (CRO) or Clinical Trials Unit (CTU) has been delegated to handle set up on behalf of the Sponsor, the contact at the CRO or CTU should be named here.	
Name	Charlotte Smith
Telephone Number	0131 651 1619
Email Address	Cahss.res.ethics@ed.ac.uk
5. * Are all participating NHS / HSC organisations undertaking the same protocol activities?	
Yes	
If 'No' give details of the activities taking place at NHS / HSC organisations that you will use this outline Organisation Information Document with. Additional outline Organisation Information Documents may be required for NHS / HSC organisations undertaking different activities.	
If no, give details	

Participating NHS / HSC Organisation Information

6. Name of Participating NHS / HSC Organisation. If this Organisation Information Document is being used as an Agreement the name must be entered prior to agreement.	
NHS Forth Valley	
7. Location/s: Please provide detail below where it is planned to undertake the research only at specified locations with the participating NHS / HSC organisation (i.e. hospital(s), GP Practice(s) and/or Research Unit(s)). It is not intended that the level of detail provided here captures individual departments within the participating NHS / HSC organisation.	
Location (enter text below)	Activity (enter text below)
NHS Forth Valley	Providing information to staff about survey Staff as participants to complete online survey

IRAS Project ID: **299667**
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Location (enter text below)	Activity (enter text below)

8 * . What is the role of the person responsible for research activities at the participating NHS / HSC organisation?

- Principal Investigators are expected to be in place at participating NHS / HSC organisations where locally employed staff take responsibility for research procedures. In this scenario Principal Investigator should be selected even for single centre studies where the Chief Investigator will also be the Principal Investigator.
- Where this is not the case, local collaborators are expected to be in place where central study staff will be present at the participating organisation to undertake research procedures (the role of the Local Collaborator is to facilitate the presence of Sponsor / CRO research staff).
- Where existing data is being provided for research purposes without additional research procedures and without the presence of central research team members at the participating NHS / HSC organisation, select Chief Investigator.

Principal Investigator

9. Contact details of person responsible for research activities at this participating NHS / HSC organisation as indicated in question 8 (if known). If known, please enter the details of the person you have spoken to about their role in this study at this participating NHS / HSC organisation. If unknown, please leave blank and that person can be identified and listed here during the setup of the study.

Name	Alistair Merrick
Post / Job Title	Trainee Clinical Psychologist
Name of Employing Organisation	NHS Forth Valley
Email Address	S2007872@ed.ac.uk
Telephone number	07939 201 009

Timescales

10. Predicted Start and End Dates of the Study at this Participating NHS / HSC Organisation The Sponsor or authorised delegate should propose a date on which it intends to start and complete research activity at this participating NHS / HSC organisation. Alternatively, this may be left blank when the Local Information Pack is shared, for agreement during study set up at the Participating NHS / HSC Organisation.	
Predicted Start Date (activities at this organisation)	31/07/2021
Predicted End Date (activities at this organisation)	30/09/2022
For many types of study the following dates are not applicable and this may be stated in answer. Where they are applicable, they should be provided by the Sponsor or authorised delegate before sharing the Local Information Pack, as indicative targets for agreement, or they may be negotiated between Sponsor or authorised delegate and participating NHS / HSC organisation after sharing the pack.	
Predicted Site Initiation Visit Date	Not applicable
Predicted Start Date for participant recruitment	31/07/2021
Predicted End Date for participants recruitment (i.e. when the study moves into "follow up" activities.)	Not Applicable (Recruitment/Participation occur simultaneously – online survey)
Predicted End Date for all study activities (i.e. "last patient visit" completed and study is ready to be archived.)	30/09/2022

Participant Numbers

11. How many research participants are expected at this participating NHS / HSC organisation? For studies not directly involving human participants, please indicate the number of samples or data-sets to be obtained. Please state if number of participants is per month, per year, overall, etc.
90 (overall)

Study set up and delivery arrangements at Participating NHS / HSC Organisations

12 * . The following are needed at the participating NHS / HSC organisation to deliver the study: e.g. specific equipment, patient/participant groups, service support, nursing time, etc. Please detail any specific requirements for participating NHS / HSC organisations to deliver this study, including by clarifying any requirements on participating NHS / HSC organisations relating to monitoring / self-monitoring, e.g. requirements for staff signature and delegation logs to be returned to the Sponsor and/or any particular access requirements that the Sponsor may have that it wishes to bring to the attention of the participating NHS / HSC organisation, likelihood of staff not employed at the participating NHS / HSC organisation coming on site, etc.
No specific equipment or resources are needed beyond access to staff participants. These participants may choose to complete the survey (max. 25mins approx.) during work hours, on breaks, or privately. Working time possibly required for participants will therefore be an individual decision made between themselves and supervisors/line management. Some limited time will be required from administration staff. However, as copy has been pre-prepared, this time commitment would be minimised. Other staff who may wish to promote the study may also forward invitation emails. Again, this would likely require a minimal time commitment and would be voluntary.
13 * . The following training will be provided by the Sponsor or authorised delegate for local research team members. Where only specific team members (e.g. the Principal Investigator) will receive this training, this should be specified.
None provided
14 * . The Sponsor expects that local research team members will have the following skills and where they do not have those skills that they will undertake the relevant training before undertaking the relevant study activities. It would not be usual for the Sponsor to expect study specific training additional to that which it will provide. This section does however allow Sponsors to state, for example, that when they expect training in Good Clinical Practice for appropriate team members where the study is a Clinical Trial of an Investigational Medicinal Product, they will accept UK nationally recognised GCP training, training recognised on the Transcelerate mutual recognition scheme, etc.
GCP training is recommended but is not mandatory
15 * . The following funding/resources/equipment, etc. is to be provided to this participating NHS / HSC organisation. The Sponsor should answer this question whether this Organisation Information Document is to be used as the Agreement with the participating NHS / HSC organisation or not. Where the document is intended as the Agreement, further detail should be provided in Appendix 2.



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No funding, resources or equipment will be provided apart from text/copy required for invitation/promotion of the study survey.	
16^ The Participating NHS / HSC Organisation confirms (by use of the drop-down box) that the Principal Investigator, where one is required, is aware of and has agreed to discharge their responsibilities in line with the UK Policy Framework for Research and Social Care ..	Confirmed
17^ The Participating NHS / HSC Organisation has considered and mitigated any conflict/s of interest declared by the principal investigator.	Not applicable
If yes, please detail conflict of interest	

Sponsor Authorisation

18 * Authorised on behalf of Sponsor by:	
Name	Clare Whittaker
Job Title	Head of Research Contracts, Governance and Integrity
Organisation Name	The University Court of The University of Edinburgh
Date	28 July 2021

Appendix L: Confirmation of Ethical Approval from University of Edinburgh School of Health in Social Science Review Board.

School of Health in Social Science Research Ethics Application

The supervisor or primary investigator must complete and sign this form after checking that all relevant sections are completed, and relevant documents are attached. For all undergraduate (UG) and MSc student projects, it is the supervisor's responsibility to submit this form and all attachments. Please note that failure to do this will result in the application being returned (and not processed) causing your research to be delayed.



Supervisor (name and UUN): Dr. Mark Hoelterhoff (UUN – mhoelter) - Lecturer in Clinical Psychology- School of Health in Social Science at University of Edinburgh, (Academic Supervisor)	
Primary Investigator (name and UUN): Alistair Merrick (UUN – s2007872) – <i>Trainee Clinical Psychologist</i>	
List of all collaborators (with affiliated institutions in brackets): Dr. Susan Ramsay – Consultant Clinical Psychologist (Occupational Health) & Psychological Therapies Training Co-ordinator (Adult Mental Health), NHS Forth Valley. (Clinical/Field Supervisor)	
Student's programme of study (if applicable): Doctorate in Clinical Psychology	
Project Title: Is psychological practitioners' self-care self-determined? The roles of autonomous motivation, job demands, mental health stigma, self-sacrifice, and perfectionism.	
Case Number (if known – assigned by Administrator at time of 1 st submission): CLPS076	
Proposed Project Start Date: 14 th August, 2021	Proposed Project End Date: 30 th September, 2022

Please indicate whether the primary investigator on this project is staff or student and select your subject area:

☐ Staff	☐ UG or MSc Student	☒ DClin Student	☐ PhD Student
☐ CPASS	☒ Clinical Psychology	☐ Nursing Studies	

This is a:

- ☐ New application for ethical review – first submission
☐ Resubmission following reviewer comments
☒ Resubmission with requested amendments

Has been reviewed by an external ethical board, such as NHS IRAS or a UK HEI (multi-site studies only) with a favourable opinion? Level 1 *

- ☐ IRAS (NHS research ethics) ☒ Other: NHS R&D (NHS Forth Valley / Nationwide).

Please tick one option that best describes your application:

- ☒ Collecting or generating new data involving other people: Level 2
☐ Extracting, re-coding and analysing existing data that contains sensitive information (i.e. identifiable information): Level 2
☐ Analysing secondary (archival) data that is routinely collected or is an existing anonymised dataset: Level 1
☐ Collecting new data BUT an external ethical review board (such as NHS IRAS; UK HEI – for multi-site studies; etc) has fully reviewed this project and generated a favourable opinion: Level 1

This application is complete with the following attachments (tick all that apply):

*If your project has been reviewed and generated an opinion by an external agency with a full ethics board, for example IRAS approval from the NHS, you only need to complete the questions related to university regulations covered in the Level 1 section of this form to ensure you are following University policies and guidelines. Please also attach the externally reviewed application and decision letter. Please note that your project will not undergo a full additional ethical review by the School of Health in Social Sciences REC, however we need to ensure your project is adhering to university regulations before you begin collecting data.

Advert/flyer ☐	Caldicott application stating what data was requested ☐	Caldicott signed approval ☐		Consent form/s ☐
Data collection tools (e.g. interview guides) ☐	Debrief with signposting ☐	IRAS application ☐	IRAS opinion letter ☐	NGO or local authority letters ☐
Participant Information Sheet/s ☒ (<i>Only change = named supervisor</i>)	Participant Information Sheet (young person version) ☐	R&D application (Submitted via IRAS) ☐	R&D approval ☐	Researcher Checklist (C-19) ☐
Risk assessment ☐	Standardised recruitment email ☒ (<i>Only change = named supervisor</i>)	Sponsorship Letter OR Email to confirm no sponsorship needed / statement explaining why sponsorship is not needed. ☒ (SEE * BELOW)		

Other attachments (please specify):

- Amendment tool confirming that proposed amendment (change of named clinical supervisor) constitutes a "non-notifiable amendment" for the purposes of NHS/Sponsor review
- *** (Amendment tool also signed / approved by the Sponsor – denoting authorisation).**
- Research CV of new Research Collaborator (new clinical supervisor).
- Updated Research Protocol (*Only change = named supervisor*)
- PDF printout of online survey (as will be presented to potential participants) (*Only change = named supervisor*)

PLEASE NOTE – ALL OTHER STUDY DOCUMENTATION HAS PREVIOUSLY BEEN REVIEWED AND APPROVED / RESULTED IN A FAVOURABLE OPINION BEING PROVIDED, AND REQUIRES NO AMENDMENT BASED ON THE PROPOSED CHANGE OUTLINED IN THIS APPLICATION. ALL DOCUMENTS ABOVE ONLY REQUIRED MODIFICATION TO REFLECT THE NAMED SUPERVISOR CHANGE.

To be completed by primary investigator or project supervisor

By signing this front sheet, I confirm that I have prepared and/or reviewed this ethics application and related documents in accordance with ethical guidelines. I also confirm I have checked that all relevant sections of the application form are completed and relevant documents are attached.

Supervisor or/PI Signature: (Mark Hoelterhoff)

Student signature: (Alistair Merrick)

Date: 29/07/2021

On completion, this Word document along with the relevant attachments should be submitted to ethics.hiss@ed.ac.uk.

Note: Please note all undergraduate and MSc applications MUST be signed and submitted by the project supervisor.

This section is to be completed after review only

ISSUES ARISING FROM THE PROPOSAL – to be completed by Ethics Reviewer

Thank you for your application. The review process has generated the following queries regarding your application. Please address the following items, and provide a note underneath each comment letting us know how you have addressed them:

General comments

It is not clear what will happen with responses if participants provide them and perhaps close their laptop (i.e. not necessarily hit 'withdraw'). Will the research team still keep this data and include it in analysis? If so this needs to be made clearer to participants in participant information sheet, consent and debrief.

Applicant Response: I have amended the participant information sheet and the matching consent information which will go at the start of the Qualtrics survey (see updated documents attached with amendments highlighted). The new wording hopefully clarifies that the only way to "leave" the study and have responses deleted is via the "withdraw" button. The new language further makes clear that partial responses (i.e. ones which remain incomplete due to a participant not withdrawing or completing the survey) may be included in data analysis. Both debrief sections of the Qualtrics survey (whether arrived at via completion or withdrawal) now also start with a reminder to download/save the updated participant information sheet which makes the above issues re: data retention clear. However, due to the design of the form, people will only arrive at the debrief section via withdrawal/completion. As there is therefore no other way to get debrief information to individuals who leave the study via other means (e.g. closing laptop), I have prioritised clarification at the consent/information stage of the survey, to enable participants to make an informed decision before proceeding.

Would suggest having a note on the participant info sheet and debrief saying to participants to either download the document for their records or to take a snapshot or image capture of the documents for their records.

Applicant Response: I have increased the font size on the relevant line in the digital participant information sheet providing clearer instruction to participants at the outset or participation to retain the document for their own records. I have also amended the language to make explicit this can be done via download, screenshot, or other methods at the discretion of each prospective participant. On the Qualtrics survey, a link is also provided reminding participants to download this information during the consent process. I have further changed the debrief section of the Qualtrics form, placing a request/reminder for participants to download the participant information sheet (if they did not already do so at the beginning as requested) at the very start of the debrief section, to maximise the chance of uptake, and provide participants with an additional opportunity to do so.

Signature:

Position: Lecturer in Applied Psychology/Ethics and Integrity Lead

Date: 2.9.21

APPLICANT'S SIGNATURE FOLLOWING REVISIONS – to be completed by applicant

I confirm that I have addressed all of the queries generated during the ethical review process of my application. I have outlined in the box above underneath each comment how each request was addressed and/or provided further clarification.

Supervisor or/PI Signature: (Mark Hoelterhoff)

Student signature: (Alistair Merrick)

Date: 02/09/2021

CONCLUSION TO ETHICAL REVIEW – to be completed by Ethics Lead

The applicant's response to our request for further clarification or changes has now satisfied the requirements for ethical practice and the application has therefore been given a favourable opinion.

Signature:

Position: Lecturer in Applied Psychology/Ethics and Integrity Lead

Date: 10.9.21

that a favourable opinion has been provided for this project (for example as an attachment to MSc dissertations).

NOTE: Once reviewed please include the page on which this box appears as a formal document demonstrating that favourable opinion has been provided for this project (for example as an attachment to MSc dissertations).

If you are applying for amendments to a previously reviewed and processed project, please use the below form to detail the amendments you wish to make:

This section is to be completed for amendments only	
AMENDMENT/S: REQUEST FOR APPROVAL – <u>to be completed by applicant</u>	
I would like to apply for the following amendments to this previously processed project which had generated a favourable opinion: The originally listed clinical supervisor for this project (Dr Martha Gillespie) has left NHS Forth Valley health board to pursue a new role elsewhere in Scotland, and hence will be unavailable to supervise the research as intended. The student applicant has therefore secured a new clinical supervisor (Dr Susan Ramsay) (see highlighted on page 1). Dr Ramsay has equivalent experience in research and data handling to Dr Gillespie, though has additional experience and interest in the study subject area (psychological staff wellbeing). This change will therefore have no material detrimental impact on the scientific value, design or methodology of the research as originally proposed. Further, Dr Ramsay is currently the chair of the local NHS Psychological Therapies Staff Wellbeing Group mentioned elsewhere in the original application, and so her involvement is likely to be a considerable asset. In response to the above change we have followed recommended procedure for notifying both the sponsor and local NHS R&D representatives of this amendment. This included the completion of an IRAS amendment tool (included with this submission) indicating that the amendment as proposed constitutes a “non-notifiable amendment”. It therefore only required that the sponsor and local NHS R&D representative be notified of the change, and this has already been completed/approved. As all other study documentation was already shared with the ethics team prior to a favourable opinion being provided, for the purposes of this amendment we have included with this submission only copies of study documentation which required modification because of the supervisor change, including: • Participant Information Sheet • Online Study Copy/Text • Email Participation Invitation Copy/Text • Research Protocol • Dr. Ramsay’s Research CV. We very much hope this is sufficient documentation in support of the proposed amendment, but of course are happy to provide any additional information required. Supervisor or/PI Signature: (Mark Hoelterhoff) Student signature: (Alistair Merrick) Date: 22/09/2021	
CONCLUSION TO ETHICAL REVIEW OF AMENDMENT – <u>to be completed by Ethics Lead</u>	

The requested amendment satisfies the requirements for ethical practice and it has therefore received a favourable opinion.

Signature:

Position: Lecturer in Applied Psychology/ Ethics and Integrity Lead

Date: 14.10.21

NOTE: Once reviewed please include the page on which this box appears as a formal document demonstrating that favourable opinion has been provided for this project (for example as an attachment to MSc dissertations).

LEVEL 1 and 2 – Confidentiality and Handling of Data

Section 1: Introduction

External Research Ethics Approval:

Does your research project require the approval of any other institution and/or ethics committee, nationally or internationally?

Note: It is each researcher's responsibility to check whether their project requires Sponsorship, Caldicott Approval, R&D approval, and/or IRAS (see <https://www.ed.ac.uk/health/research/ethics/sponsorship-and-governance>). The principal investigator is responsible for ensuring compliance with any additional ethical requirements that might apply, and/or for compliance with any additional requirements for review by external bodies.

☐ This research project does not require external ethics approval.

OR

If you require external approval, please state the name of the review body:

☐ IRAS (NHS research ethics)

☐ Local Authority

☒ Other: NHS R&D

NB: If you require external approval from IRAS/NHS/Caldicott, you must have external approval before submitting your application for School of Health in Social Science Research Ethics approval. You can only submit your application to us once external approval has been obtained, and you must include all documentation including your application to and approval of external approval as an attachment.

If you require approval from a **local authority**, you must first receive ethics approval from the School of Health in Social Science Research Ethics Committee, before submitting your application to the local authority.

Q1. Project summary

Please provide a brief summary of your proposed study. Do not exceed 1500 words. Our interest is in areas of your methodology where ethical issues may arise so please focus your detail on areas such as recruitment, consent, describing your participants and the nature of their involvement, and data handling.

Research Introduction (Purpose/Justification):

It is important that practitioner psychologists maintain their own mental and physical wellbeing to be able to do their job effectively. It is often recommended they do this via "self-care", or looking after themselves before problems develop (e.g. by reporting difficulty, speaking to others for support). Unfortunately, lots of psychologists don't self-care when needed. Research suggests this is perhaps because of:

- High workload demands.
- Difficulty acknowledging personal wellbeing needs (as they are mental health workers, seen as "experts" on wellbeing).
- Commonly identified traits in psychologists including prioritising working hard to high standards and looking after others over themselves (self-sacrifice).
- What motivates their self-care. Research shows pressuring people to engage in health-promoting behaviours isn't as effective as helping people find their own reasons to enact them.

This study proposes using an anonymous online survey to ask qualified and trainee psychological practitioners about their experiences of these factors. Analysis will explore relationships between these factors and self-care (e.g., do people self-care less if they have a higher workload?). This will help inform services and future research regarding optimising psychologist self-care engagement, and consequently psychologist wellbeing and patient care.

A non-experimental, cross-sectional study design will explore relationships between dependent variables (self-care behaviours), and independent variables in two categories: (1) Autonomous motivation towards self-care; (2) Known occupational/personal barriers to self-care (perceived workload, perceptions of role-related stigma, the presence of drives for either self-sacrifice or meeting perfectionistic standards). This design minimises intrusion/demands for NHS staff relative to longitudinal approaches.

Recruitment:

Participants will be identified by their being either (a) Employed as a psychological practitioner in NHS Forth Valley (student researcher's home health board), as e.g. Trainee/Qualified Clinical Psychologists, Counselling Psychologists, Other Qualified/Accredited Psychotherapists, Assistant Psychologists, Trainee/Qualified Clinical Associates in Applied Psychology; (b) Enrolled in either Edinburgh or Glasgow Universities doctoral programmes in Clinical Psychology. Pending ethical approval, remote access has already been granted to these populations (See "survey approval" documents included).

In NHS Forth Valley, a psychological therapies staff wellbeing steering group exists. Representatives collect staff wellbeing data via monthly electronic survey, sharing the link and promoting its completion within teams via email. This group has approved and will support the sharing/promotion of the online survey proposed in this application via this established route. Participation and informed consent will be further supported by the student researcher offering to speak at relevant departmental team meetings (staff wellbeing is a service-wide standing agenda item). Participation from within the two doctoral programmes will be promoted via emails from respective course administrators, with the lead researcher's contact information provided to facilitate enquiry and support informed consent.

Should these routes fail to recruit the required number of participants (92, based on a priori statistical analysis), additional recruitment methods may be deployed. These include invitations for participation being extended via other educational organisations and professional organisations which work with or represent trainee or qualified psychological practitioners. Examples include, but are not limited to, The Universities of Edinburgh, Dundee and Stirling Clinical Associates in Applied Psychology programmes, Caledonian University Doctoral training programme in Counselling Psychology), course centres providing accredited qualifications in CBT, and professional organisations (e.g. British Psychological Society or The British Association for Behavioural & Cognitive Psychotherapies). Should these routes also fail participation will be invited via social media platforms, relevant professional message boards for psychological practitioners (e.g. psychological practitioner Facebook groups). Further, peers and colleagues of the researchers, and NHS staff comprising the local psychological services staff wellbeing representatives, will share invitations to participate among their relevant professional contacts, and encourage these to be snowballed onwards.

Participation:

Following any amendments necessitated by the university ethics approval procedures, potential participants will be provided initial information regarding the research in the form of pre-prepared invitation copy and/or a digital promotional poster. They will also be provided with an anonymous web link directing them to complete the research survey should they wish via the Qualtrics® online platform. It is anticipated that the duration of required participant involvement, including reading of promotional information / invitations to participate, completion of the consent process and questionnaire will not exceed more than 27 minutes in total (reading provided optional debrief information will increase total participation time, though this will be voluntary).

Data Management / Privacy:

Response data relating to experimental variables of interest will not constitute personal data as they report non-unique attitudes/behaviours. There is a very limited possibility that demographic items obtained, in combination or alongside other information available to the researchers (from working in the same health board/university where data is being gathered) may enable identification. These demographic variables include gender, age, years in the profession, qualification status (qualified vs. trainee), contracted working hours, full/part-time status, percentage of working hours spent in direct client contact vs other non-contact work (e.g. research/admin/academic study, work setting (urban/rural/mixed).

To address this, no name, job title or other identifying contact information will be gathered, and thus each participants' responses will be as fully anonymised as possible. Further, participants will be made aware of the limited possibility of identification, and the names of all three researchers with potential access to the data, during the consent gathering process. This will enable participants to make an informed decision regarding whether to proceed, based on their own levels of concern and risk of identification. Further, throughout the online survey, participants will be repeatedly presented with the option to cease participation and have their previous data deleted via a "withdraw" button at the bottom of all data entry pages.

All data, including the potential personal data outlined above, will be stored on secure University of Edinburgh data servers, initially as raw response data in the named student's Qualtrics account, and then in password-protected Excel or SPSS files stored within the named student's university Onedrive account. This data will be primarily accessed by the named student only. Access to this data will only be granted to other named researchers and will be limited to the minimum access to data required to assist with specified aspects of analysis.

Data collected or generated by the study (including potential personal data) will not be transferred to any external individuals or organisations outside of the Sponsoring organisation(s). Upon completion of the named student's university studies, data will be securely electronically transferred to the named academic supervisor.

Risk / Informed Consent:

Regarding potential adverse impacts on participants, the research will require those taking part to reflect on their approach to self-care and several aspects of their working practice including beliefs/attitudes regarding themselves and peers/colleagues. Self-reflection inherently involves the potential for both positive and negative self-evaluation on the part of participants, which could result in consequently experiencing positive or negative thoughts and feelings.

However, self-awareness and reflective practice are recognised as core competencies for psychological practitioners. Further, professional practice guidelines require psychological practitioners to proactively attend to and maintain their own well-being (ie, self-care). It is therefore highly likely participants will already have routinely reflected on the topics raised by the proposed research. The risk of this research inducing additional psychological stress or discomfort via self-reflection would therefore be judged as very low.

Nonetheless, to further minimise participant risk, the following measures are proposed:

1. During the consent procedure for the online survey individuals will be informed of the specific topics they will be reminded of and asked to reflect on the potential for positive or negative self-evaluation, and consequent stress or discomfort. Participants will therefore be better able to evaluate their own risk of distress and whether to proceed.
2. Debriefing materials provided to participants at the end of the survey will provide context for topics discussed relative to the scientific literature. For example, it will emphasise workload demands are a common source of distress in psychological practitioners, that psychological practitioners commonly hold themselves to high standards of personal accomplishment (leading to distress), and that psychological practitioners experience

several barriers to self-care. This will contextualise and validate participants' experiences in order to minimise negative self-evaluation and reduce potential psychological distress or discomfort.

3. Up-to-date links and recommendations regarding relevant sources of support will be provided to all participants in the debriefing information. These will include recommendations to discuss any work-related issues arising via established routes of supervision (supervisors/line managers) and potentially trusted peers as appropriate. Links to current sources of support for psychological distress and discomfort (e.g. The National Wellbeing Hub, Breathing Space etc) will also be included. This will offer participants a range of options for varied eventualities.

4. In line with ACCORD guidance, participant information sheets will include details for a relevant contact within the University of Edinburgh for filing any complaints arising relating to the research proposed.

[1443 words]

Q2. Will you collect or use NHS data?

☐ Yes ☒ No

Q3. What information about participants/data subjects will you collect and/or use?

Dependent Variables (and measures used):	Independent Variables (and measures used):	Demographic / Control Variables:
Self-Care Behaviour Domain (SCAP) - Professional Support - Professional Development - Life Balance - Cognitive Awareness - Daily Balance	- Autonomous motivation towards self-care (C-RAI). - Perceived work demands (HSEMS-IT). - Stigma (beliefs/attitudes regarding occupational stress and burnout in mental health professionals) (MHPSS). - Unrelenting performance standards / perfectionism (SAPS). - Self-sacrifice (UCS-R)	- Gender - Age - Years in the profession. - Qualification status (qualified vs. trainee). - Contracted working hours. - Full/part-time status. - Percentage of working hours spent in direct client contact vs other non-contact work (e.g. research/admin/academic study). - Work setting (urban/rural/mixed). (All gathered via dedicated Qualtrics Survey Items).
KEY:		
Abbreviation: SCAP	Measure: The Self-Care Assessment for Psychologists - Dorociak, K. E., Rupert, P. A., Bryant, F. B., & Zahniser, E. (2017). Development of a Self-Care Assessment for Psychologists. <i>Journal of Counseling Psychology</i> , 64(3), 325–334. https://doi.org/10.1037/cou0000206	
C-RAI	The Comprehensive Relative Autonomy Index - Sheldon, K. M., Osin, E. N., Gordeeva, T. O., Suchkov, D. D., & Sychev, O. A. (2017). Evaluating the Dimensionality of Self-Determination Theory's Relative Autonomy Continuum. <i>Personality and Social Psychology Bulletin</i> , 43(9), 1215–1238. https://doi.org/10.1177/0146167217711915	
HSEMS-IT	The Health and Safety Executive Management Standards Indicator Tool ("Demands")	

	Subscale) - Health and Safety Executive. (2020). <i>Work related stress - Tools and templates</i> . https://www.hse.gov.uk/stress/standards/downloads.htm
MHPSS	Mental Health Professional Stigma Scale - Clough, B. A., Hill, M., Delaney, M., & Casey, L. M. (2020). Development of a measure of stigma towards occupational stress for mental health professionals. <i>Social Psychiatry and Psychiatric Epidemiology</i> , 1–11. https://doi.org/10.1007/s00127-019-01820-9
SAPS	The Almost Perfect Scale-Revised (Short-form) - Rice, K. G., Richardson, C. M. E., & Tueller, S. (2014). The Short Form of the Revised Almost Perfect Scale. <i>Journal of Personality Assessment</i> , 96(3), 368–379. https://doi.org/10.1080/00223891.2013.838172
UCS-R	The Revised Unmitigated Communion Scale - Fritz, H. L., & Helgeson, V. S. (1998). Distinctions of Unmitigated Communion From Communion: Self-Neglect and Overinvolvement With Others. <i>Journal of Personality and Social Psychology</i> , 75(1), p121-140. https://oae-ovid-com.ezproxy.is.ed.ac.uk/article/00005205-199807000-00009/HTML

Q4. What training will staff who have access to the data receive on their responsibilities for its safe handling? Have all staff and students who have access completed the mandatory data protection training on the self-enrolment page of Learn?

CVs (including research experience/training) for all persons who will potentially have access to the data are included with this application and are summarized below. Please note, most of the data access/analysis will be conducted by the Principal Investigator / Student Researcher):

Alistair Merrick – Principal Investigator / Student Researcher:

- Repeated and completed “Introduction to Good Clinical Practice” (GCP) eLearning (June 2020 Release) (**15th April 2021**)
- Completed “Data Protection Training” via Learn (**19th March, 2021**).
- Completed “Data Protection for Research” via Learn (**19th March, 2021**).
- Completed NHS Forth Valley mandatory eLearning (**NHS FV: Data Protection**) via Learnpro as condition of ongoing employment with NHS Forth Valley (**17th November, 2020, valid for one year**)
- Completed “Introduction to Good Clinical Practice” (GCP) eLearning (December 2018 Release) and MANTRA Research Data Management Training (**17th January, 2020**).
- Receiving ongoing teaching/training as an enrolled student on the University of Edinburgh Doctorate in Clinical Psychology programme. Topics covered to date include dedicated lectures on Research Fundamentals, Creating a Thesis, Service-based research, Ethics and Data Management, and Research Methodology (including Qualitative and Quantitative approaches, Statistics, Psychometrics and single case research).

Dr. Mark Hoelterhoff – Chief Investigator / Academic Supervisor:

- Postgraduate training Trinity International University
- Psych Research Methods 1994
- Guided Research 1995
- Postgraduate training Alliant University
- Statistics 1995

- Research Design 1998
- Project Design 1998
- Postgraduate training University of Plymouth
- Research Design 2005
- PPLS Analysis 2009
- CPD at University of Edinburgh
- Doctoral Supervision seminar 2018
- Digital Culture in Clinical Education 2019
- Data Protection Training 2019

Dr Martha Gillespie – Research Collaborator / Clinical Supervisor:

- Clinical Psychology Doctorate 2016 – 2019 – University of Edinburgh - Training related to research design, methodology and conduct delivered throughout the training programme.
- In addition to info on CV, individual is required, like student researcher, to complete NHS Forth Valley mandatory eLearning (**NHS FV: Data Protection**) via Learnpro as condition of ongoing employment with NHS Forth Valley.

Note - As outlined above, the two individuals with access to University of Edinburgh Resources via Learn (mandatory data protection training) have completed the mandatory data protection training.

Q5. Will the information include special categories of personal data (health data, data relating to race or ethnicity, to political opinions or religious beliefs, trade union membership, criminal convictions, sexual orientations, genetic data and biometric data)?

☐ Yes

☒ No

If “yes” – Explain what safeguards e.g. technical or organisational you have in place; including any detailed protocols if this requires special and/or external processing, storage, and analysis.

Q6. Please indicate how your research is in the public interest:

- ☒ Your research is proportionate
- ☐ Your research is subject to a governance framework
- ☐ Research Ethics Committee (REC) review (does not have to be a European REC)
- ☐ Peer review from a funder
- ☐ Confidentiality Advisory Group (CAG) recommendation for support in England and Wales or support by the Public Benefit and Privacy Panel (PBPP) for Health and Social Care in Scotland
- ☐ Other

Q7. It is essential that you identify, and list all risks to the privacy of research participants. You will then need to consider the likelihood of the risks actually manifesting and the severity of harm if the risks actually manifest.

Risk	Likelihood of risk manifesting			Severity of harm		
	Remote	Possible	Probable	Minimal	Significant	Severe
Identifiable due to data linkage	☒	☐	☐	☒	☐	☐
Identifiable due to low participant numbers	☒	☐	☐	☒	☐	☐
Identifiable due to geographical location	☒	☐	☐	☒	☐	☐
Identifiable due to transfer of data	☒	☐	☐	☒	☐	☐
Identifiable due to access of data	☒	☐	☐	☒	☐	☐
Distress / Discomfort arising from self-reflection on potentially stress-inducing professional issues or self-evaluations.	☒	☐	☐	☒	☐	☐

Please use this text box to record any other risks and the likelihood of them occurring, along with the severity of harm. Please also use this when dealing with secondary data.

No other risks are anticipated aside from possible experiences of distress/discomfort, however these issues and preventative/remediating steps to mitigate against them are discussed above (Q1 – Project Summary).

Please identify measures you could take to reduce or eliminate risks identified as possible/significant or probable/severe.

N/A – No such risks identified.

Q8. Will information containing personal, identifiable data be transferred to, shared with, supported by, or otherwise available to third parties outside the University?

☐ Yes ☒ No

If “yes” - Please explain why this necessary and how the transfer of the information will be made secure. If the third party is based outside the European Economic Area please obtain guidance from the Data Protection Officer.

Q9. Other than the use by third parties, will the data be used, accessed or stored away from University premises?

☒ Yes ☐ No

If “yes” - Describe the arrangements you have put in place to safeguard the data from accidental or deliberate access, amendment or deletion when it is not on University premises, including when it is in transit, and (where applicable) it is transferred outside the EEA.

While the data will at all times be stored on GDPR compliant University of Edinburgh Servers (within Qualtrics/Office 365 cloud services) the data may be accessed from other computers (e.g. at student's home) by logging in to Microsoft Office Cloud Services remotely. This will primarily be to (1) Enable statistical analysis by the principal investigator / student researcher while working at home on study days (2) Enable the chief investigator / academic supervisor to view data if required to do so to be able to offer suggestions/guidance regarding statistical analysis. Data access will remain secure as access will require relevant password access to cloud services hosting the files, no local copies will be retained, and these services enable the restriction of access to files to particular authorised usernames. All files will therefore be locked for editing and viewing to anyone outside the immediate research team.

Q10. Will feedback of findings be given to your research project participants or data subjects?

☒ Yes

☐ No

If "yes" - How and when will this feedback be provided?

Participants will have the opportunity to contact the research team during/following participation via the survey and contact information included within the participant debrief information provided. Participants can thereby request feedback on the overall research results/findings. Those who have specifically requested to be informed of findings will be contacted via email and provided a summarised report from the student researcher. This will take place no later than September 2022 pending successful completion of the student's course of Doctoral Study and validation of their findings.

Further, a similar preliminary summarized report will be shared with all participant organisations and will be shared via the same digital means as used during recruitment of all participants. Further, pending COVID protocols, in-person or virtual presentation sessions will be made available to all participant organisations/teams, and contact information shall be provided for the principal investigator on all summary reports, enabling the arrangement of further individual or group presentations/discussions of findings by request.

If "no" - Please provide rationale for this.

N/A

Q11. How do you intend to use/disseminate the results of your research project?

In addition to the feedback methods outlined above, the researchers will seek to further disseminate the results via publication in peer-reviewed scientific journals and via conference/other poster presentations (e.g. as part of local CPD or conferences held by relevant professional bodies).

Section 2: Security-sensitive material

The Terrorism Act (2006) outlaws the dissemination of records, statements and other documents that can be interpreted as promoting or endorsing terrorist acts.

Q12. Does your research involve the storage on a computer of any such records, statements or other documents?

☐ Yes ☒ No (if you answered no to this question please jump to section 3)

If "yes" - Please type 'Yes' to indicate that you agree to store all documents on that file store

Q13. Might your research involve the electronic transmission (for example, as an email attachment) of such records or statements?

☐ Yes ☒ No

If "yes" - Please type 'Yes' to indicate that you agree not to transmit electronically to any third party documents stored in the file store

Q14. Will your research involve visits to websites that might be associated with extremist, or terrorist, organisations?

☐ Yes ☒ No

If "no", please proceed to Question 15.

If "yes" - You are advised that such sites may be subject to surveillance by the police. Accessing those sites from University IP addresses might lead to police enquiries. Please type 'Yes' to acknowledge that you understand this risk

By submitting to the ethics process, you accept that your School Research Ethics Officer and the convener of the University's Compliance Group will have access to a list of titles of documents (but not the contents of documents) in your document store. *Please type 'Yes' to acknowledge that you accept this.*

Please confirm that you have contacted your School Research Ethics Officer to discuss security-sensitive material by ticking 'Yes'

- ☐ Yes, I have contacted my School's Research Ethics Officer
☐ No, I have not contacted my School's Research Ethics Officer

Section 3: Copyright

Q15. Does your project require use of copyrighted material?

☒ Yes ☐ No

If “yes” please give further details

Some psychometric measures proposed for use by this study (The SCAP, C-RAI, UCS-R) are the copyrighted / intellectual property of their original authors. In all cases, permission for use has been obtained and documented via email correspondence with the lead authors of the original research papers validating the measures. All other measures are provided free to use for research purposes (with attribution).

Section 4: Good conduct in collaborative research

Q16. Does your project involve working collaboratively with other academic partners?

☒ Yes ☐ No (if you answered no to this question please jump to section 5)

If "yes" - Is there a formal agreement in place regarding a collaborative relationship with the academic partner(s)?

Yes. In line with The University of Edinburgh's document "*Authorship: Principles for Clinical Psychology at Edinburgh*", a formal authorship agreement has been completed between the research student, academic supervisor and clinical supervisor. The completion of this document was informed by also completing an authorship determination scorecard, enabling relative and expected contributions to the project to be discussed and agreed. These documents can be made available on request.

If "no" - Please explain why there is no formal agreement in place

Q17. Does your project involve working collaboratively with other non-academic partners?

☐ Yes ☒ No

If "yes" - Is there a formal agreement in place regarding a collaborative relationship with the non-academic partner(s)?

If "no" - Please explain why there is no formal agreement in place.

While informal feedback regarding the proposed research has and may be further obtained from relevant parties (e.g. working/trainee psychological practitioners), this information has and will only be used to inform the research approach ultimately decided among the three aforementioned collaborators (student, academic, and clinical supervisors). While it is intended this will remain the case for the duration of the research, should other individuals make contributions which constitute an activity category outlined in the authorship determination scorecard, they shall be included in a revised authorship agreement.

Q18. Does your project involve employing local field assistants (including guides/translators)?

☐ Yes ☒ No

If "yes" - Is there a formal agreement in place regarding the employment of local field assistants (including guides and translators)?

If "no" - Please explain why there is no formal agreement in place

The only assistance provided locally will be minimal and will be limited to forwarding email invitations to participants and limited promotional activities (e.g. mentioning/reminding potential participants of the opportunity to take part in the research while in routine team meetings). The individuals assisting will be doing so as part of their existing role remits as administrators or staff representatives with responsibility for engaging local staff in wellbeing initiatives and relevant research. As such it was felt a formal agreement would not be required.

Q19. Will care be taken to ensure that all individuals involved in implementing the research adhere to the ethical and research integrity standards set by the University of Edinburgh?

☒ Yes ☐ No

If "no" - Please explain why care will not be taken

Q20. Have you reached agreement relating to intellectual property?

☒ Yes ☐ No

If "no" - Please explain why you have not reached agreement

The University of Edinburgh legal default position is that the student retains any intellectual property resulting from research completed. However, the two documents completed and referenced previously in **Q16** (authorship agreement and authorship determinations scorecard) represent the agreed and proportional contributions of each aforementioned researcher to any shared collective intellectual property arising from the research proposed. These shall form the basis for proportional attribution and compensation regarding the future use/exploitation of any intellectual property generated. It should be noted that commercial exploitation of generated intellectual property is not anticipated based on the nature of the research proposed.

Section 5: Good conduct in publication practice

In publication and authorship, as in all other aspects of research, researchers are expected to follow the University's guidance on [integrity](https://www.ed.ac.uk/governance-strategic-planning/content-to-be-removed/research-integrity). <https://www.ed.ac.uk/governance-strategic-planning/content-to-be-removed/research-integrity>. By ticking yes, you confirm that full consideration of the items described in this Section will be addressed as applicable

☒ Yes

☐ No

If you intend to collect new data, please continue completing the Level 2 application in the next page.

If you are NOT collecting any new data, you have now completed the Level 1 application. Please submit this document alongside all attachments to ethics.hiss@ed.ac.uk.

LEVEL 2 ONLY – Participant Risk and Information

The following Sections are to be completed if you are collecting new data. Please do not complete it if you are using existing data.

Section 6: Potential risks to participants and researchers

Q21. Is your research project likely or possible to induce any psychological stress or discomfort in the participants or others, indirectly associated with the research?

☒ Yes

☐ No

If “yes” state the types of risk and what measures will be taken to deal with such problems

There is a very limited possibility of participant’s experiencing potential adverse impacts (psychological stress or discomfort).

The research will require those taking part to reflect on their approach to self-care and several aspects of their working practice including beliefs/attitudes regarding themselves and peers/colleagues. Self-reflection inherently involves the potential for both positive and negative self- evaluation on the part of participants, which could result in consequently experiencing positive or negative thoughts and feelings.

However, self-awareness and reflective practice are recognised as core competencies for psychological practitioners in training and beyond. Further, professional practice guidelines note the importance of psychological practitioners attending to and maintaining their own well-being and considering their own self-care. It is therefore highly likely that intended participants will already have reflected on at least some if not most of the topics raised by the proposed research as part of their routine practice. Pre-qualified participants will also at minimum be developing experience in successfully self-managing their own reflections on their professional practice. The risk of this research inducing additional psychological stress or discomfort via self-reflection could therefore be judged as very low.

Nonetheless, to further minimise risk to participants, the following measures are proposed:

1. As part of the consent procedure for the online survey, prior to participation individuals will be informed of the specific topics they will be asked to reflect on. They will also be reminded that such reflection has the potential to induce stress or discomfort via positive or negative self-evaluation. Participants will therefore be better able to evaluate their own risk of distress and whether to proceed.

2. Debriefing material provided to participants at the end of the survey will provide context for each topic discussed in the survey in terms of findings from the scientific literature. For example, it will emphasise that workload demands are a common source of distress in psychological practitioners, that it is common for psychological practitioners to hold themselves to high standards of personal accomplishment (in turn leading to distress), and for psychological practitioners to experience barriers towards self-care. This will hopefully contextualise participants’ experiences in a way which validates their experiences, minimises

the chances of negative self-evaluation, and thus reduces their risks of psychological distress or discomfort.

3. Up-to-date links and recommendations regarding relevant sources of support will be provided to all participants as part of the debriefing information. These will include recommendations to discuss any work-related issues arising via established routes of supervision (supervisors/line managers) and potentially trusted peers as appropriate. Links to current sources of support for psychological distress and discomfort (e.g. The National Wellbeing Hub, Breathing Space etc.) will also be included. This will offer participants a range of options for varied eventualities.

4. In line with ACCORD guidance, participant information sheets will include details for a relevant contact within the University of Edinburgh for filing any complaints arising relating to the research proposed.

Q22. Does your research project require any physically-invasive or potentially physically harmful procedures?

☐ Yes ☒ No

If "yes" give details and outline procedures to be put in place to deal with potential problems.

N/A

Q23. Does your research project require the use of privacy-invasive technology, such as CCTV, biometrics, facial recognition, vehicle tracking software?

☐ Yes ☒ No

If "yes" - Give details and outline procedures to be put in place to deal with potential problems.

N/A

Q24. Does your research project involve the investigation of any illegal behaviour or activities?

☐ Yes ☒ No

If "yes" - Give details of any illegal behavior or activities you may investigate

N/A

Q25. Is it possible that your research project will lead to awareness or the disclosure of information about child abuse or neglect?

☐ Yes ☒ No

If "yes" - Indicate the likelihood of disclosure and the procedures to be followed if you become aware that a child has been or may be at risk of harm

N/A

Q26. Is it likely that dissemination of research findings or data could adversely affect participants or others indirectly associated with the research?

☐ Yes ☒ No

If "yes" - Describe the potential risk for participants/data subjects of this use of the data. Outline any steps that will be taken to protect participants.

N/A -

Q27. Could participation in this research adversely affect participants and others associated with the research in any other way?

☒ Yes ☐ No

If "yes" - Describe the possible adverse effects and the procedures to be put in place to protect against them.

There is a very limited possibility that demographic items obtained, in combination or alongside other information available to the researchers (from working in the same health board/university where data is being gathered) may enable identification of participants. These variables include gender, age, years in the profession, qualification status (qualified vs. trainee), contracted working hours, full/part-time status, percentage of working hours spent in direct client contact vs other non-contact work (e.g. research/admin/academic study, work setting (urban/rural/mixed)).

To addressing this risk, no name, job title or other identifying contact information will be gathered, and thus each participants' responses will be as fully anonymised as possible. Further, participants will be made aware of the limited possibility of identification, and the names of all three researchers with potential access to the data, during the consent gathering process. This will enable participants to make an informed personal decision as to whether to proceed, based on their own levels of concern and potential personal anticipated risk or consequences of being identified from demographic data alone. Further, throughout the completion of the online survey, participants will be repeatedly presented with the option to cease participation and have their previous data deleted via a "withdraw" button at the bottom of all data entry pages.

Q28. Is this research expected to benefit the participants, directly or indirectly?

☒ Yes ☐ No

If "yes" - Give details of how this research is expected to benefit the participants.

In terms of potential direct benefits, it may be beneficial for participants to realise they could be doing more to prioritise their self-care, address potentially unhelpful attitudes relating to themselves or their work, or may benefit from addressing workload issues with their supervisors/managers or other forms of support. It will also hopefully be reassuring for staff to realise that staff wellbeing is being examined to improve how this is addressed in the wider NHS/other services.

However, as the above cannot be guaranteed, participant information shall not promise direct benefits to participants. Participants will however be informed that by sharing their experiences they will be helping the researchers better understand what supports or prevents psychological practitioners' self-care, and that

this information may in turn be used to indirectly benefit themselves and others. For example, the research may feasibly support wider awareness of issues and the need for service improvements in participating organisations (when results of the research are fed back) or via further research which may benefit psychological practitioners, their services, and their patients more widely.

Q29. Will the true purpose of the research be concealed from the participants/data subjects?

☐ ~~Yes~~ ☒ No

If "yes" - Explain what information will be concealed and why.

N/A

Q30. Will participants/data subjects be debriefed at the conclusion of the study?

☒ Yes ☐ ~~No~~

If "no" - Why will participants / data subjects not be debriefed?

Q31. At any stage in this research could researchers' safety be compromised, or could the research induce emotional distress in the researchers?

☐ ~~Yes~~ ☒ No

If "yes" - Give details and outline procedures to be put in place to deal with potential problems.

N/A

Please tick to confirm you agree with the following:

I will adhere to School guidance on risk assessment and health and safety and will seek advice on project and travel insurance prior to project commencement.

- ☒ I agree
- ☐ I do not agree
- ☐ Not applicable

Section 7: Participants and data subjects.

Q32. How many participants or data subjects are expected to be included in your research project?

A priori power calculations determined a minimum sample requirement of N=92 would be required for the proposed research and analysis (5 experimental independent variables, 15 control covariates including demographic items or potential confounders).

Q33. What criteria will be used in deciding on the inclusion and exclusion of participants/data subjects in your research project?

Inclusion Criteria:

(All must be met)

1. Participants must be currently employed both (a) By a UK-based health or social care organisation, in either the statutory or third sector, AND (b) As a psychological practitioner in a regulated qualified or pre-qualification role (Doctor of Clinical Psychology, Counselling Psychologist, Other Qualified/Accredited Psychotherapist, Psychological Wellbeing Practitioner, Primary Care Mental Health Worker, Assistant Psychologist, Trainee Clinical Psychologist, Trainee Clinical Associate in Applied Psychology).
2. Participants must have been working in one or some combination of the aforementioned roles for at least the past 2 months (with no significant recent absences if new in the role).
3. Participants must be able to communicate in English (psychometric measures proposed have not undergone multilingual validation).
4. Participant must have normal vision (or corrected to normal vision with the use of visual aids e.g. glasses, contact lenses).
5. Participants are over 18 years of age (with no maximum age limit).

Exclusion Criteria:

1. Individuals working solely in private practice (as the organisational context and role demands cannot be adequately presumed or ascertained).

Q34. Are any of the participants or data subjects likely to be under 16 years of age?

☐ Yes ☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

N/A

Q35. Are any of the participants or data subjects likely to be children in the care of a Local Authority?

☐ Yes ☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

N/A

Q36. Are any of the participants or data subjects likely to be known to have additional support needs?

☐ Yes ☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

N/A

Q37. In the case of participants with additional support needs, will arrangements be made to ensure informed consent?

☐ Yes ☐ No ☒ N/A

If "yes" - What arrangements will be made?

N/A

If "no" - Please explain why not

N/A

Q38. Are any of the participants or data subjects likely to be physically or mentally ill?

☐ Yes ☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

N/A

Q39. Are any of the participants or data subjects likely to be vulnerable or likely exposed to harm in other ways?

☐ Yes ☒ No

If "yes" - Explain and describe the nature of the vulnerability and the measures that will be used to protect and/or inform participants/data subjects.

N/A

Q40. Are any of the participants or data subjects likely to be unable to communicate in the language in which the research is conducted?

☒ Yes

☐ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

N/A

Q41. Are any of the participants or data subjects likely to be in a relationship (i.e., professional, student-teacher, other dependent relationship) with the researchers?

☒ Yes

☐ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

As previously outlined in response to **Q27**, all researchers work in either the same health board or university where data is being gathered. This means respondents may include managers, supervisors, or peers who presently or may in future have established working relationships with the researchers.

As previously discussed (**Q27**) the primary risk in this case would be judged to be possible identification of individual participants' responses by the researchers. Again, measures are in place to ensure each participants' responses will be as fully anonymised as possible, and participants will be made aware of the names of all three researchers with potential access to the data, during the consent gathering process. This will enable potential participants to make an informed personal decision as to whether to proceed considering their own unique risk of identification, and how this may detrimentally impact current or potential working relationships.

Again, throughout the completion of the online survey, participants will also be repeatedly presented with the option to cease participation and have their previous data deleted via a "withdraw" button at the bottom of all data entry pages.

Q42. Are any of the participants or data subjects likely to have difficulty in reading and/or comprehending any printed material distributed as part of the study?

☐ Yes

☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

N/A

Q43. Describe how the sample will be recruited.

Participants will be identified by their being either (a) Currently employed as a psychological practitioner in NHS Forth Valley; (b) Currently enrolled in either the Edinburgh or Glasgow University doctoral programmes in Clinical Psychology. In the case of (a) this identification will be conducted and email invitations will be sent by either the Psychological Therapies admin staff (with responsibility for sending service-wide emails to psychological practitioners) or a member of the NHS Forth Valley Psychological Therapies Staff Wellbeing Steering Group. In the case of (b) this identification will be conducted and emails will be sent by the respective DClinPsy course administrators in Edinburgh or Glasgow Universities.

In NHS Forth Valley, the psychological therapies staff wellbeing steering group collects staff data by monthly

electronic survey and promotes its completion within teams. This group has approved the researcher sharing/promoting their proposed online survey via this established route to approach potential participants. Participation and informed consent will be further supported by the lead researcher offering to speak at all departmental team meetings, as staff wellbeing is a service-wide standing agenda item. Participation from within the two doctoral programmes will be promoted via emails from respective course administrators, with the lead researcher's contact information provided to facilitate enquiry and support recruitment.

Should these routes fail to recruit the required number of participants, additional recruitment methods may be deployed. These include recruitment utilising the same methods as described previously, in which contact will be made and invitations for participation will be extended via other educational organisations and professional organisations which work with or represent trainee or qualified psychological practitioners. Examples may include, but are not limited to, The Universities of Dundee and Stirling (both of which administer training programmes for Clinical Associates in Applied Psychology), Caledonian University (which administers a doctoral training programme in Counselling Psychology), and course centers providing accredited qualifications in CBT, and professional organisations (e.g. British Psychological Society or The British Association for Behavioural & Cognitive Psychotherapies). Should these routes also fail participation will be invited via advertisement on social media platforms and relevant professional message boards for psychological practitioners (e.g. psychological practitioner Facebook groups). Further, peers and colleagues of the researchers, and NHS staff comprising the local psychological services staff wellbeing representatives, will share invitations to participate among their relevant professional contacts, and encourage these to be snowballed onwards.

Q44. Will participants receive any financial or other material benefits as a result of participation?

☐ Yes

☒ No

If "yes" - What benefits will be offered to participants and why?

N/A

Section 8: Participant or data subject information and consent

Q45. Will written or oral consent be obtained from all participants or data subjects?

☒ Yes

☐ No

If “yes” – attach participant information sheet and consent form and detail the process you will follow.

If “no” – explain why not and what process you will follow regarding consent, or if consent cannot or should not be sought for some reason, please provide a clear case and rationale for this (e.g. in international contexts where speaking to foreign researchers is prohibited).

Prior to being directed via link to the online survey, promotional information will provide an overview of the proposed research to support informed consent. If choosing to participate, an information page will start the online Qualtrics survey, expanding on prior information received by participants, outlining all information recommended by relevant ethical guidance to ensure consent (BPS, 2014). Including:

- Identify of the data controller (The University of Edinburgh, represented by the lead researcher)
- Sufficient information to enable participants to understand the project is examining and what is required of them.
- Any possible risks arising from participation and where required steps taken to minimise this risk.
- Consent to participate in the research.
- The legal basis on which the research is lawful.
- Contact information in the event of more information being required (researchers’ contact details), an independent contact for complaints, and the contact details of the University of Edinburgh’s Data Protection Officer (dpo@ed.ac.uk)
- Details of how participants can exercise their rights (right to opt-out of research right to withdrawal within specified time-frame).
- Information assuring how their data will be securely held.
- An explanation that if the research project changes in any way, the amended participant information sheet will be made available via the same methods used for recruitment.

This page will also be made available as a downloadable PDF sent out with the original invitation and available to download prior to participation for potential participants own records. Participants will be able to take as long as they wish to review/consider the above before choosing to participate. Explicit consent/debrief statements will bookend the survey, broken into subsections requiring check-box approval, to maximize readability and confirm understanding of each key aspect of participation.

Q46. Have you made arrangements to tell participants what information you will hold about them and for how long?

☒ Yes

☐ No

If “yes” - what arrangements have been made?

Information held and duration of retention is outlined in the attached participant information sheet which will be provided as part of the recruitment for the survey and will also form part of the consent process when participants complete the online form and consent process.

If “no” – why not?

N/A

Q47. Have you made arrangements to tell participants whether you will disclose the information to other organisations?

☐ Yes ☐ No ☒ N/A

If "yes" - What arrangements have been made?

If "no" - why not?

Q48. Have you made arrangements to tell participants whether you will combine that information with other data?

☐ Yes ☐ No ☒ N/A

If "yes" - What arrangements have been made?

Q49. In the case of children participating in the research, will the consent or assent of parents be obtained?

☐ Yes ☐ No ☒ N/A

If "yes" - Explain how this consent or assent will be obtained

If "no" - Please explain why you won't be obtaining consent

Q50. Will the consent or assent of children participating in the research be obtained?

☐ Yes ☐ No ☒ N/A

If "yes" - Explain how this consent or assent will be obtained

If "no" - Please explain why not

Q51. In the case of participants who are not proficient in the language in which the research is conducted, will arrangements be made to ensure informed consent?

☐ Yes ☐ No ☒ N/A

If "yes" - What arrangements will be made?

If "no" - Please explain why not

Q52. Does the activity involve using cookies or tracking individual's activity on a website or the Internet in general?

☒ Yes

☐ ~~No~~

If "yes" – Describe the arrangements you have put in place to obtain informed consent for the use of these tools

The use of cookies to prevent multiple responses of "ballot stuffing" has been implemented on the online form. It will also enable participants to return to the page and resume filling in the survey from where they left off.

The use of these cookies is highlighted in the attached participant information sheet which will be provided as part of the recruitment for the survey and will also form part of the consent process when participants complete the online form.

You have now completed the Level 2 application. Please submit this document alongside all attachments to ethics.hiss@ed.ac.uk.

Appendix M: Confirmation of Ethical Approval from NHS Forth Valley's Research and Development Office.

NHS Forth Valley

Carseview House
Castle Business Park
Stirling
FK9 4SW

Telephone:
Fax:



Dr. Mark Hoelterhoff
School of Health in Social Science,
University of Edinburgh Medical School,
Doorway 6, Teviot Place
Edinburgh
EH8 9AG

Date	26 July 2021
Your Ref	
R&D Ref	FV1321
Enquiries to	Fv.randd-depart@nhs.scot
Extension	
Direct Line:	01324 614690

Dear Dr Hoelterhoff

Study title: Is psychological practitioners' self-care self-determined? The roles of autonomous motivation, job demands, mental health stigma, self-sacrifice, and perfectionism.

REC reference: N/A

I am pleased to confirm that I formally gave Management Approval to the study above on 26 July 2021

This approval is granted subject to your compliance with the following:

1. Any amendments to the protocol or research team must have Ethics Committee (where required) and R&D approval (as well as approval from any other relevant regulatory organisation) before they can be implemented. Please ensure that the R&D Office and (where appropriate) NRS-PCC are informed of any amendments as soon as you become aware of them.

2. You and any local Principal Investigator are responsible for ensuring that all members of the research team have the appropriate experience and training, including GCP training if required.

3. If someone working within NHS Forth Valley is recruiting participants, those figures MUST be recorded on the EDGE research management system. If recruitment is all being handled outside Forth Valley, you will be contacted monthly for the latest recruitment figures.

4. All study activity must also be recorded on EDGE, to ensure that we receive the appropriate funding for each study.

All relevant study staff should have been added to EDGE by the R&D Office and received a New Users Guide and Researchers' Guide. Please follow the instructions in these documents to record the required information

5. All those involved in the project will be required to work within accepted guidelines of health and safety and data protection principles, any other relevant statutory legislation, UK Policy Framework for Health and Social Care Research and IHC-GCP guidelines. A copy of the Framework can be accessed at: <http://www.nhsresearchscotland.org.uk/uploads/tinymce/uk-policy-framework-health-social-care-research%20v1.1.pdf> and ICH-GCP guidelines may be found at <http://www.ich.org/LOB/media/MEDIA482.pdf>

6. As custodian of the information collected during this project you are responsible for ensuring the security



Chair: Janie McCusker
Chief Executive: Cathie Cowan

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW
www.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalley

of all personal information collected in line with NHS Scotland IT security policies, until the destruction of this data.

7. You or the local Principal Investigator will be required to provide the following reports and information during the course of your study:

- Copies of any sponsor monitoring reports (the R&D Office may request further information after each report) OR Quality Check information requested by the R&D office either annually or 6-monthly
- Report on SAEs and SUSARs if your study is a Clinical Trial of an Investigational Medicinal Product
- Any information required for the purpose of internal or external audit and monitoring
- Notification of the end of recruitment and the end of the study
- A copy of the final report, when available.
- Copies of or full citations for any publications or abstracts

The appropriate forms will be provided to you by the Research and Development office when they are needed. Other information may be required from time to time.

Yours sincerely

Pp
MR. ANDREW MURRAY
Medical Director

CC:

Appendix N: Emailed Survey Invitation Text Sent to All Participants.



Research Invitation Email Copy:

Is Psychological Practitioners' Self-Care Self-Determined?
DRAFT V2 – 22/09/2021

Hello,

You are being invited to participate in research examining self-care in psychological practitioners. We have contacted you because you are either a qualified or trainee psychological practitioner currently working in a clinical capacity.

We hope to explore how often psychological practitioners' self-care, the possible barriers they may experience, and what motivates them to self-care.

Taking part involves completing a brief online survey. Participation will require a maximum of around 25 minutes of your time. This includes first reading the participant information and giving consent (max. 15 mins). If you are happy to proceed, you can then complete the 10-minute online survey. You may do these two tasks separately and at times most convenient to yourself.

The participant information is attached to this email, and is also available at the start of the survey. Please read this to find out more about the study. You can access the survey and take part using your computer, tablet or smartphone, via the link below:

[STUDY LINK GOES HERE]

If you wish to know more about the research, or have any questions about your participation, please email Alistair Merrick (*Lead Researcher*) at

Many thanks for reading and for considering taking part in our research.

Alistair Merrick (*Trainee Clinical Psychologist, NHS Forth Valley / University of Edinburgh*)
Dr. Mark Hoelterhoff (*Programme Director for Staff Learning and Teaching Development - School of Health in Social Science, University of Edinburgh*)
Dr Susan Ramsay (*Consultant Clinical Psychologist & Psychological Therapies Training Co-ordinator, NHS Forth Valley*).

Appendix O: Survey Promotional Poster.



THE UNIVERSITY of EDINBURGH
School of Health in
Social Science

Are you a psychological practitioner?

Either trainee or qualified – including Clinical or Counselling Psychologists, Accredited Psychological Therapists, Clinical Associates in Applied Psychology, Primary Care Mental Health Workers, Psychological Wellbeing Practitioners, Assistant Psychologists.

Would you like to take part in research on staff self-care?



- We are asking for people to complete a brief online survey (approx. 25 minutes).
- We hope to explore how often psychological practitioners self-care, possible barriers they may experience, and what motivates them to self-care.

To find out more and to take part, please follow the link below:

(either click on the link, or copy/paste into your web browser's address bar)

www.surveylinkgoeshere.com

You can also contact the researcher if you have any questions:

Alistair Merrick
Trainee Clinical Psychologist
Email:

Thank you for reading!

Icons made by "Freepik" from www.flaticon.com

Is psychological practitioners' self-care self-determined? - V1 - 26.05.21

Page 1 of 1

Appendix P: C-RAI Items Modified for the Current Study.

Amotivation Items

1. I'm not sure, I wonder whether I should continue doing self-care.
2. I used to know why I did self-care, but I don't anymore.
3. I once had good reasons for doing self-care, but now I don't.
4. Honestly, I don't know why I would self-care.

External Motivation Items

1. Because I'll get in trouble if I don't do self-care.
2. Because I don't have any choice but to do self-care.
3. Because if I don't do self-care, others will get upset.
4. Because important people (i.e., family, co-workers) will like me better if I self-care.

Negative Introjection Items

1. *
2. Because I would feel ashamed if I didn't self-care.
3. *
4. Because I would feel guilty if I didn't self-care.

Positive Introjection Items

1. *
2. Because self-care boosts my self-esteem.
3. *
4. *

Identified Motivation Items

1. Because I strongly value self-care.
2. Because self-care is personally important to me.
3. Because it is my personal choice to do self-care.
4. Because self-care is meaningful to me.

Intrinsic Motivation Items

1. Because self-care is interesting.
2. Because I enjoy self-care.
3. Because it is a pleasure to do self-care.
4. Because self-care is fun.

NOTE: The above are new items created for the purposes of this study based on item stems provided and used with the permission of the original author K.M. Sheldon (personal communication, 24th July 2020).

* indicates items which were non-modifiable. These items are available to be viewed within the original study paper (Sheldon et al., 2017).

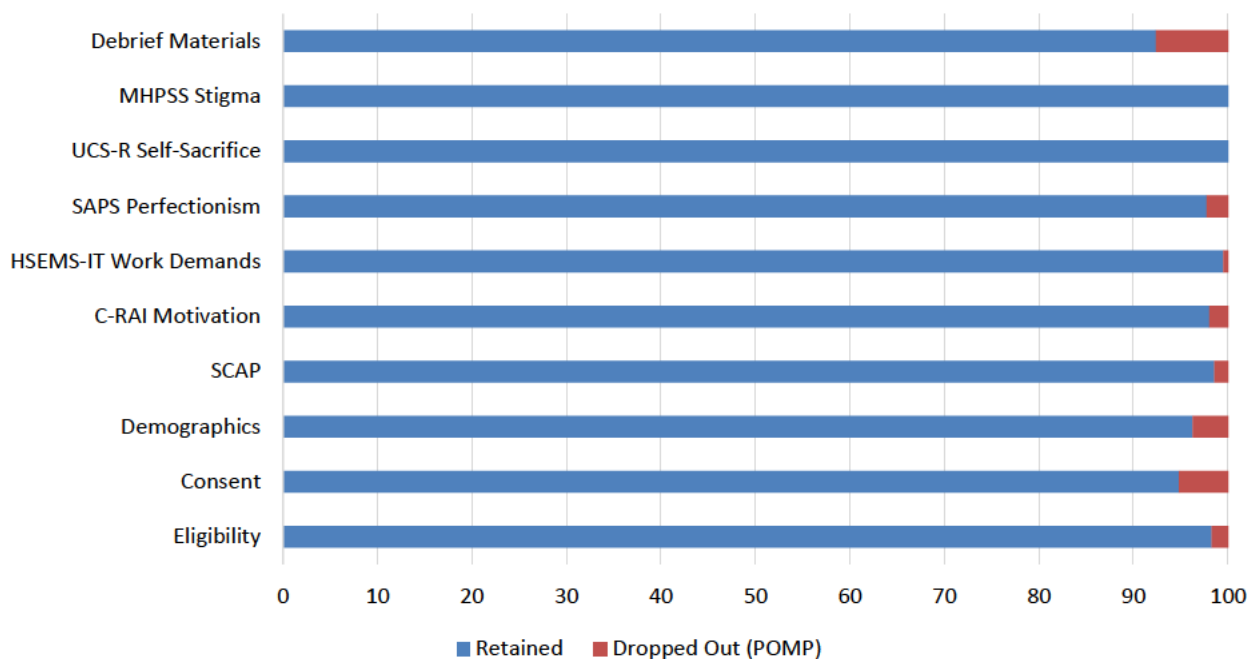
Appendix Q: Attrition Data for the Survey.

Survey Attrition at Each Survey Stage (*Number of Participants*)

	Eligibility	Consent	Demographics	SCAP	C-RAI	HSEMS-IT	SAPS	UCS-R	MHPSS	Debrief Materials	Complete survey
Progressed past this stage	443	420	404	398	390	388	379	379	379	350	350
Cumulative Attrition	8	31	47	53	61	63	72	72	72	101	101
Dropped out at this stage	8	23	16	6	8	2	9	0	0	29	0

Key. SCAP = Self-Care Assessment for Psychologists; C-RAI = Comprehensive Relative Autonomy Index; HSEMS-IT = The Health and Safety Executive Management Standards Indicator Tool; SAPS = The Almost Perfect Scale-Revised (Short-form); UCS-R = The Revised Unmitigated Communion Scale; MHPSS = Mental Health Professional Stigma Scale.

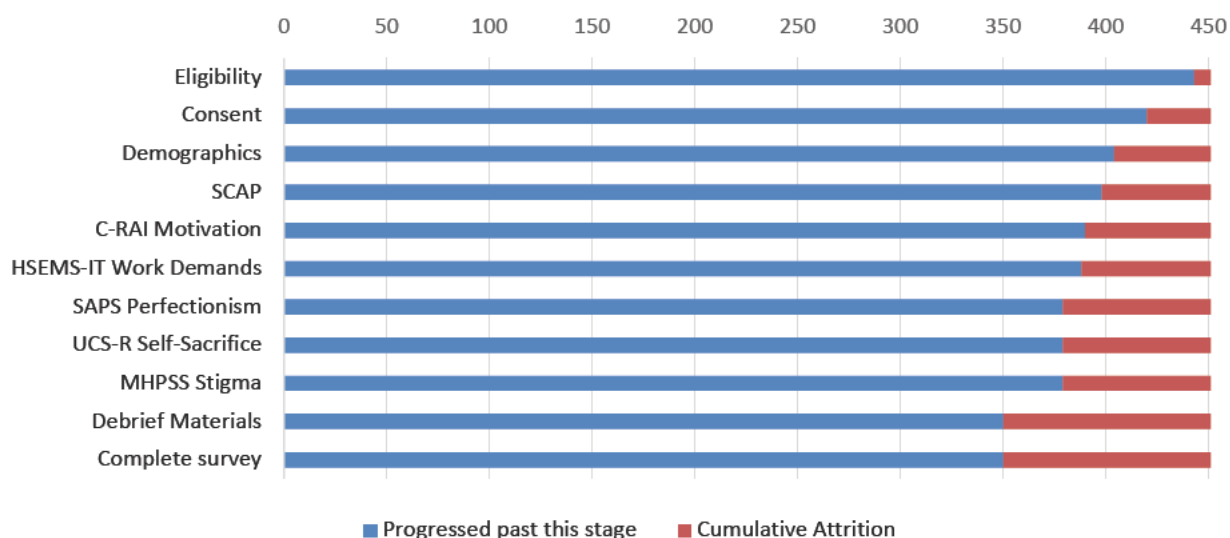
Relative Attrition at Each Survey Stage



Note. Figures expressed are as percentage of maximum possible (POMP), indicating the percentage of respondents who dropped out at each stage as a percentage of those still undertaking the survey by this point.

Key. SCAP = Self-Care Assessment for Psychologists; C-RAI = Comprehensive Relative Autonomy Index; HSEMS-IT = The Health and Safety Executive Management Standards Indicator Tool; SAPS = The Almost Perfect Scale-Revised (Short-form); UCS-R = The Revised Unmitigated Communion Scale; MHPSS = Mental Health Professional Stigma Scale.

Cumulative Attrition at Each Survey Stage



Note. Figures expressed are based on the original respondent pool of $N=451$. Cumulative attrition represents the proportion of all respondents who had dropped out by this stage of the study.

Key. SCAP = Self-Care Assessment for Psychologists; C-RAI = Comprehensive Relative Autonomy Index; HSEMS-IT = The Health and Safety Executive Management Standards Indicator Tool; SAPS = The Almost Perfect Scale-Revised (Short-form); UCS-R = The Revised Unmitigated Communion Scale; MHPSS = Mental Health Professional Stigma Scale.

Appendix R: Calculations Conducted to Identify Insufficient Effort Responding.

Longstring Calculations.

An Excel macro was used to identify respondents' maximum longstring for each measure. When determining a maximum longstring cut-off to detect insufficient-effort responding, it is recommended best practice to consider positive/negative item wordings and scale dimensionality, being lenient where required (Desimone et al., 2015). Regarding multidimensional measures, as it is possible for individuals to equally use or ignore many distinct types of self-care (SCAP) (Norcross & VandenBos, 2018b), or to experience multiple forms of motivation (C-RAI), stigma (MHPSS) and perfectionism (SAPS) simultaneously (Clough et al., 2020; Howard et al., 2020; Rice et al., 2014), no longstring cut-offs were set based on dimensionality. However, as both the UCS-R and MHPSS have reverse coded items, the longstring value for these scales were set respectively at 8 and 7, these being the largest possible strings of consecutive similarly coded items. For all measures, a percentage of maximum possible (POMP)(P. Cohen et al., 1999) score was created, dividing individual respondents maximum longstrings by either full scale length (SCAP, C-RAI, HSEMS-IT, SAPS) or the longest possible consecutive similarly-coded items (UCS-R, MHPSS), and enabling comparability between all measures (Moeller, 2015). Longstring outliers were detected by values exceeding 1.5 times the interquartile range of the median, used as a more robust measure of central tendency in data likely skewed by outliers' presence (Diez et al., 2019).

Response Time.

Considering the respondents' likely high workloads and time pressure, it was anticipated excessively short and excessively long responses may both be possible, due respectively to hurrying, or leaving and returning to the survey when more available. Given the former is more likely to be indicative of insufficient effort responding (Desimone et al., 2015), no maximum cut-off time was determined. Page completion time captured by Qualtrics® (the time spent by each respondent on each survey page) was used to assess response speed (Huang et al., 2012). Minimum response time cut-offs for each page were derived based on recommended bare minimums of two seconds per item (Desimone et al., 2015; Huang et al., 2012), and an additional three to five seconds for reading initial page information, based on item character length (S. Wise & Kong, 2005). These page times were compared to timing data recorded during useability beta testing of the survey, and notably would have flagged most non-psychotherapist respondents instructed not to expend effort considering answers. Cut-off times for each page were used to calculate a response time effort (RTE) index score following the method outlined by S. Wise & Kong (2005), quantifying potential rapid guessing behaviour for each participant across the whole survey. Outliers on the low end of the sample distribution were identified (Meade & Craig, 2012) by considering values exceeding 1.5 times the interquartile range below the median ($RTE > .83$).

Appendix S: Hierarchical Regression Analyses Results for Professional Support Self-Care.

Hierarchical regression model relating professional support self-care to demographic, intrapersonal, work, stigma, and motivational factors.

Variables Incl.	Model				Independent Variables					
	R^2	SE	R^2 (Adj.)	p (Change)	B	SE	95% CI (B)		p	sr_i^2
							LB	UB		
1 Demographics	.01	14.72	<.01	.449						
Male ^a					-1.72	2.54	-6.71	3.27	.497	.00
Neither gender ^a					-11.60	8.58	-28.48	5.27	.177	.01
Age					0.00	0.16	-0.32	0.31	.978	.00
Years in relevant role					0.13	0.17	-0.21	0.47	.464	.00
Being unqualified ^b					-0.39	1.80	-3.93	3.14	.827	.00
2 Intrapersonal	.09	14.18	.06	<.001*						
High standards					0.19	0.04	0.10	0.28	<.001*	.05
Discrepancy/concerns					-0.16	0.03	-0.22	-0.09	<.001*	.06
Self-sacrifice					0.00	0.05	-0.11	0.10	.959	.00
3 Work Demands (Obj.)	.12	14.11	.06	.277						
Part-time working ^c					1.22	1.91	-2.53	4.97	.524	.00
Weekly hours					0.19	0.13	-0.07	0.46	.155	.01
% Clinical work weekly					-0.07	0.03	-0.14	-0.01	.033*	.01
Urban work setting ^d					-1.91	1.65	-5.21	1.27	.232	.00
Rural work setting ^d					1.21	2.08	-2.88	5.29	.562	.00
^ High standards					0.19	0.04	0.10	0.27	<.001*	.04
^ Discrepancy/concerns					-0.16	0.03	-0.23	-0.10	<.001*	.06
4 Work Demands (Perc.)	.12	14.11	.06	.277						
HSEMS-IT Demands					-0.05	0.04	-0.16	0.01	.100	.01
5 Stigma	.21	13.41	.14	<.001*						
Perceived struct. Stigma					-0.27	0.05	-0.36	-0.17	<.001*	.07
Self-stigma					-0.07	0.04	-0.15	0.01	.067	.01
Perceived other stigma					0.10	0.06	-0.02	0.22	.100	.01
Personal stigma					-0.07	0.05	-0.16	0.04	.205	.00
^ High standards					0.17	0.04	0.09	0.25	<.001*	.03
^ Discrepancy/concerns					-0.15	0.03	-0.21	-0.08	<.001*	.04
6 Motivation	.41	13.18	.16	.001*						
Relative autonomy					0.29	0.10	0.10	0.48	.002*	.02
Mean motivation					0.20	0.08	0.04	0.36	.015*	.01
^ Perceived struct. Stigma					-0.25	0.05	-0.35	-0.16	<.001*	.06
^ High standards					0.14	0.04	0.06	0.23	.001*	.02
^ Discrepancy/concerns					-0.13	0.03	-0.19	-0.06	<.001*	.03

Note. Each block included all variables from previous blocks as covariates. Tests of significance refer only to variables added at each stage. ^ denotes variables which remained subsequently significant after correcting for family-wise type I error rate ($\alpha = .05$). Work Demands (Obj.) refers to objective measures of work demand. Work Demands (Perc.) refers to perceived work demands as measured by the HSEMS-IT.

a = Dummy variable coded from categorical gender item with 3 original categories. Comparison group = female.

b = Comparison group = holding a professional qualification to practice psychotherapy.

c = Comparison group = full time working pattern.

d = Dummy variable coded from categorical work setting item with 3 original categories. Comparison group = mixed work setting.

* = Individual Result significant ($p < .05$)

Bold* = Result remained significant after correcting for family-wise type I error rate ($\alpha = .05$) using Holm-Bonferroni method.

Appendix T: Hierarchical Regression Analyses Results for Professional Development Self-Care.

Hierarchical regression model relating professional development self-care to demographic, intrapersonal, work, stigma, and motivational factors.

	Variables Incl.	Model				Independent Variables					
		<i>R</i> ²	<i>SE</i>	<i>R</i> ²	<i>p</i>	<i>B</i>	<i>SE</i>	95% CI (<i>B</i>)		<i>p</i>	<i>sr</i> ²
				(Adj.)	(Change)			LB	UB		
1	Demographics	.01	14.84	.01	.74						
	<i>Male^a</i>					-1.42	2.56	-6.45	3.61	.580	.00
	<i>Neither gender^a</i>					-2.99	8.65	-20.00	14.02	.730	.00
	<i>Age</i>					-0.17	0.16	-0.48	0.15	.29	.00
	<i>Years in relevant role</i>					0.21	0.17	-0.14	0.55	.238	.00
	<i>Being unqualified^b</i>					-1.40	1.81	-4.96	2.16	.44	.00
2	Intrapersonal	.06	14.49	.03	<.001*						
	<i>High standards</i>					0.17	0.05	0.08	0.26	<.001*	.03
	<i>Discrepancy/concerns</i>					-0.13	0.03	-0.19	-0.06	<.001*	.03
	<i>Self-sacrifice</i>					-0.01	0.05	-0.11	0.10	.909	.00
3	Work Demands (Obj.)	.08	14.41	.03	.106						
	<i>Part-time working^c</i>					2.85	1.95	-0.97	6.68	.144	.01
	<i>Weekly hours</i>					0.18	0.14	-0.09	0.45	.186	.00
	<i>% Clinical work weekly</i>					-0.03	0.04	-0.10	0.04	.427	.00
	<i>Urban work setting^d</i>					-1.24	1.68	-4.54	2.07	.463	.00
	<i>Rural work setting^d</i>					4.19	2.12	0.02	8.36	.049	.01
^	<i>High standards</i>					0.17	0.05	0.08	0.26	<.001*	.03
^	<i>Discrepancy/concerns</i>					-0.13	0.03	-0.19	-0.06	<.001*	.03
4	Work Demands (Perc.)	.12	14.14	.06	<.001*						
	<i>HSEMS-IT Demands</i>					-0.16	0.04	-0.25	-0.08	<.001*	.04
^	<i>High standards</i>					0.17	0.04	0.08	0.26	<.001*	.04
5	Stigma	.16	13.89	.09	.002*						
	<i>Perceived struct. Stigma</i>					-0.19	0.05	-0.29	-0.10	<.001*	.04
	<i>Self-stigma</i>					-0.06	0.04	-0.14	0.02	.153	.01
	<i>Perceived other stigma</i>					0.12	0.06	0.00	0.25	.056	.01
	<i>Personal stigma</i>					-0.03	0.05	-0.13	0.07	.578	.00
^	<i>High standards</i>					0.16	0.04	0.07	0.25	<.001*	.03
^	<i>HSEMS-IT Demands</i>					-0.13	0.04	-0.21	-0.05	.003*	.02
6	Motivation	.17	13.83	.09	.091						
	<i>Relative autonomy</i>					0.15	0.10	-0.05	0.35	.135	.01
	<i>Mean motivation</i>					0.14	0.09	-0.03	0.31	.101	.01
^	<i>High standards</i>					0.15	0.04	0.06	0.23	.001	.03
^	<i>Perceived struct. Stigma</i>					-0.19	0.05	-0.28	-0.09	<.001*	.03

Note. Each block included all variables from previous blocks as covariates. Tests of significance refer only to variables added at each stage. ^ denotes variables which remained subsequently significant after correcting for family-wise type I error rate ($\alpha = .05$). Work Demands (Obj.) refers to objective measures of work demand. Work Demands (Perc.) refers to perceived work demands as measured by the HSEMS-IT.

a = Dummy variable coded from categorical gender item with 3 original categories. Comparison group = female.

b = Comparison group = holding a professional qualification to practice psychotherapy.

c = Comparison group = full time working pattern.

d = Dummy variable coded from categorical work setting item with 3 original categories. Comparison group = mixed work setting.

* = Individual Result significant ($p < .05$)

Bold* = Result remained significant after correcting for family-wise type I error rate ($\alpha = .05$) using Holm-Bonferroni method.

Appendix U: Hierarchical Regression Analyses Results for Life Balance Self-Care.

Hierarchical regression model relating life balance self-care to demographic, intrapersonal, work, stigma, and motivational factors.

Variables Incl.	Model				Independent Variables					
	R^2	SE	R^2	p	B	SE	95% CI (B)		p	sr_i^2
			(Adj.)	(Change)			LB	UB		
1 Demographics	.04	14.39	.01	.018*						
Male ^a					-7.17	2.48	-12.05	-2.30	.004*	.02
Neither gender ^a					4.09	8.39	-12.40	20.58	.626	.00
Age					-0.19	0.16	-0.50	0.11	.212	.00
Years in relevant role					0.06	0.17	-0.28	0.39	.740	.00
Being unqualified ^b					-2.90	1.76	-6.35	0.55	.099	.01
2 Intrapersonal	.10	13.97	.06	<.001*						
High standards					0.03	0.04	-0.06	0.11	.541	.00
Discrepancy/concerns					-0.14	0.03	-0.20	-0.07	<.001*	.04
Self-sacrifice					-0.05	0.05	-0.15	0.05	.352	.00
^ Male ^a					-7.93	2.44	-12.72	-3.13	.001*	.03
3 Work Demands (Obj.)	.10	14.01	.05	.697						
Part-time working ^c					0.11	1.89	-3.61	3.83	.954	.00
Weekly hours					-0.12	0.13	-0.38	0.15	.384	.00
% Clinical work weekly					-0.05	0.03	-0.11	0.02	.171	.00
Urban work setting ^d					-0.64	1.64	-3.85	2.58	.698	.00
Rural work setting ^d					0.21	2.06	-3.85	4.26	.919	.00
^ Male ^a					-7.53	2.49	-12.64	-2.84	.002*	.02
^ Discrepancy/concerns					-0.14	0.03	-0.20	-0.08	<.001*	.04
4 Work Demands (Perc.)	.11	13.99	.05	.152						
HSEMS-IT Demands					-0.06	0.04	-0.14	0.02	.152	.01
^ Male ^a					-7.72	2.48	-12.59	-2.85	.002*	.02
^ Discrepancy/concerns					-0.13	0.03	-0.19	-0.06	<.001*	.04
5 Stigma	.14	13.86	.06	.032*						
Perceived struct. stigma					-0.11	0.05	-0.21	-0.01	.025*	.01
Self-stigma					-0.06	0.04	-0.14	0.02	.118	.01
Perceived other stigma					0.10	0.06	-0.02	0.23	.107	.01
Personal stigma					-0.08	0.05	-0.18	0.03	.151	.01
^ Discrepancy/concerns					-0.13	0.03	-0.19	-0.06	<.001*	.03
6 Motivation	.21	13.32	.13	<.001*						
Relative autonomy					0.42	0.10	0.23	0.61	<.001*	.04
Mean motivation					0.31	0.08	0.15	0.47	<.001*	.03

Note. Each block included all variables from previous blocks as covariates. Tests of significance refer only to variables added at each stage. ^ denotes variables which remained subsequently significant after correcting for family-wise type I error rate ($\alpha = .05$). Work Demands (Obj.) refers to objective measures of work demand. Work Demands (Perc.) refers to perceived work demands as measured by the HSEMS-IT.

a = Dummy variable coded from categorical gender item with 3 original categories. Comparison group = female.

b = Comparison group = holding a professional qualification to practice psychotherapy.

c = Comparison group = full time working pattern.

d = Dummy variable coded from categorical work setting item with 3 original categories. Comparison group = mixed work setting.

* = Individual Result significant ($p < .05$)

Bold* = Result remained significant after correcting for family-wise type I error rate ($\alpha = .05$) using Holm-Bonferroni method.

Appendix V: Hierarchical Regression Analyses Results for Daily Balance Self-Care.

Hierarchical regression model relating daily balance self-care to demographic, intrapersonal, work, stigma, and motivational factors.

Variables Incl.	Model				Independent Variables					
	R^2	SE	R^2	p	B	SE	95% CI (B)		p	sr_i^2
			(Adj.)	(Change)			LB	UB		
1 Demographics	.05	21.28	.03	.001*						
Male ^a					2.87	3.67	-4.34	10.08	.434	.00
Neither gender ^a					24.33	12.41	-0.07	48.72	.051	.01
Age					0.62	0.23	0.17	1.07	.007*	.02
Years in relevant role					-0.94	0.25	-1.43	-0.45	<.001*	.04
Being unqualified ^b					0.26	2.60	-4.84	5.37	.919	.00
2 Intrapersonal	.10	20.82	.07	<.001*						
High standards					-0.09	0.07	-0.22	0.04	.173	.00
Discrepancy/concerns					-0.08	0.05	-0.17	0.02	.122	.01
Self-sacrifice					-0.17	0.08	-0.32	-0.02	.025*	.01
^ Years in relevant role					-0.95	0.24	-1.43	-0.47	<.001*	.04
3 Work Demands (Obj.)	.11	20.87	.06	.668						
Part-time working ^c					1.67	2.82	-3.87	7.22	.554	.00
Weekly hours					0.09	0.20	-0.30	0.48	.664	.00
% Clinical work weekly					-0.08	0.05	-0.18	0.02	.114	.01
Urban work setting ^d					-0.64	2.44	-5.42	4.16	.795	.00
Rural work setting ^d					1.85	3.07	-4.20	7.89	.548	.00
^ Years in relevant role					-0.97	0.25	-1.46	-0.48	<.001*	.04
4 Work Demands (Perc.)	.27	18.89	.22	<.001*						
HSEMS-IT Demands					-0.51	0.06	-0.62	-0.40	<.001*	.16
5 Stigma	.29	18.83	.22	.176						
Perceived struct. stigma					0.04	0.07	-0.09	0.17	.578	.00
Self-stigma					-0.13	0.06	-0.23	-0.02	.024	.01
Perceived other stigma					0.08	0.09	-0.09	0.25	.358	.00
Personal stigma					-0.01	0.07	-0.15	0.13	.92	.00
^ HSEMS-IT Demands					-0.52	0.06	-0.64	-0.41	<.001*	.16
6 Motivation	.38	17.55	.32	<.001*						
Relative autonomy					0.75	0.13	0.50	1.00	<.001*	.06
Mean motivation					0.54	0.11	0.33	0.75	<.001*	.04
^ HSEMS-IT Demands					-0.47	0.05	-0.36	-0.48	<.001*	.13

Note. Each block included all variables from previous blocks as covariates. Tests of significance refer only to variables added at each stage. ^ denotes variables from which remained subsequently significant. Work Demands (Obj.) refers to objective measures of work demand. Work Demands (Perc.) refers to perceived work demands as measured by the HSEMS-IT.

a = Dummy variable coded from categorical gender item with 3 original categories. Comparison group = female.

b = Comparison group = holding a professional qualification to practice psychotherapy.

c = Comparison group = full time working pattern.

d = Dummy variable coded from categorical work setting item with 3 original categories. Comparison group = mixed work setting.

* = Individual Result significant ($p < .05$)

Bold* = Result remained significant after correcting for family-wise type I error rate ($\alpha = .05$) using Holm-Bonferroni method.

Appendix W: Hierarchical Regression Analyses Results for Cognitive Awareness Self-Care.

Hierarchical regression model relating cognitive awareness self-care to demographic, intrapersonal, work, stigma, and motivational factors.

Variables Incl.	Model				Independent Variables					
	R^2	SE	R^2 (Adj.)	p (Change)	B	SE	95% CI (B)		p	sr^2
							LB	UB		
1 Demographics	.00	13.91	.02	.904						
Male ^a					-1.99	2.40	-6.70	2.73	.408	-.04
Neither gender ^a					5.53	8.11	-10.41	21.47	.496	.04
Age					-0.01	0.15	-0.31	0.28	.941	-.01
Years in relevant role					-0.04	0.16	-0.36	0.28	.823	-.02
Being unqualified ^b					-0.73	1.70	-4.07	2.61	.667	-.02
2 Intrapersonal	.09	13.32	.06	<.001*						
High standards					0.21	0.04	0.13	0.29	<.001*	.06
Discrepancy/concerns					-0.11	0.03	-0.17	-0.05	<.001*	.03
Self-sacrifice					-0.13	0.05	-0.22	-0.03	.009*	.02
3 Work Demands (Obj.)	.12	13.74	.06	.109						
Part-time working ^c					-1.18	1.79	-4.69	2.35	.512	.00
Weekly hours					-0.20	0.13	-0.45	0.05	.112	.01
% Clinical work weekly					-0.07	0.03	-0.14	-0.01	.027*	.01
Urban work setting ^d					0.13	1.55	-2.91	3.17	.932	.00
Rural work setting ^d					2.58	1.95	-1.26	6.41	.187	.00
^ High standards					0.21	0.04	0.13	0.29	<.001*	.06
^ Discrepancy/concerns					-0.11	0.03	-0.17	-0.05	<.001*	.03
4 Work Demands (Perc.)	.12	13.22	.06	.128						
HSEMS-IT Demands					-0.06	0.04	-0.14	0.02	.128	.01
^ High standards					0.21	0.04	0.13	0.29	<.001*	.06
^ Discrepancy/concerns					-0.10	0.03	-0.16	-0.04	.002	.02
5 Stigma	.16	12.98	.09	.002*						
Perceived struct. stigma					-0.11	0.05	-0.20	-0.02	.017	.01
Self-stigma					-0.11	0.04	-0.18	-0.03	.005*	.02
Perceived other stigma					0.03	0.06	-0.08	0.15	.576	.00
Personal stigma					0.00	0.05	-0.10	0.10	.981	.00
^ High standards					0.20	0.04	0.12	0.28	<.001*	.05
6 Motivation	.24	12.44	.16	<.001*						
Relative autonomy					0.44	0.09	0.26	0.62	<.001*	.05
Mean motivation					0.27	0.08	0.12	0.42	.001	.03
^ High standards					0.16	0.04	0.09	0.24	<.001*	.04

Note. Each block included all variables from previous blocks as covariates. Tests of significance refer only to variables added at each stage. ^ denotes variables from which remained subsequently significant. Work Demands (Obj.) refers to objective measures of work demand. Work Demands (Perc.) refers to perceived work demands as measured by the HSEMS-IT.

a = Dummy variable coded from categorical gender item with 3 original categories. Comparison group = female.

b = Comparison group = holding a professional qualification to practice psychotherapy.

c = Comparison group = full time working pattern.

d = Dummy variable coded from categorical work setting item with 3 original categories. Comparison group = mixed work setting.

* = Individual Result significant ($p < .05$)

Bold* = Result remained significant after correcting for family-wise type I error rate ($\alpha = .05$) using Holm-Bonferroni method.

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