Psychologist Burnout: Exploring the Causes, Consequences, and Coping Strategies of Burnout Among Public Psychologists in New Zealand

A thesis

submitted in fulfilment

of the requirements for the degree

of

Masters of Social Sciences in Psychology

at

The University of Waikato

by

ALEXIS FRASER

THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

2025

Abstract

Burnout is a common experience among professionals working in the public health sector that can negatively impact their personal and professional life (Lu et al., 2020; Salyers et al., 2015; Stone et al., 2021; Zarei et al., 2019). Mental health workers are particularly vulnerable to experiencing burnout due to the demands of high needs clients and the lack of resources (Fischer et al., 2007; Kumar et al., 2011). Although burnout has been widely studied internationally, there are very few studies in New Zealand that have investigated burnout among psychologists. Additionally, the burnout literature has predominantly focused on quantitative reporting of prevalence, with limited qualitative studies hearing from psychologists' personal experiences. Therefore, the aim of this study was to explore the experiences, implications, and preventative solutions of burnout among psychologists in New Zealand. I recruited 14 registered psychologists working in the public sector to complete one semi-structured interview about the causes, consequences, and protective ways of coping with burnout. I analysed the data using thematic analysis, results showed that systematic issues were the most common cause for burnout in particular high workload and understaffing. Burnout had serious implications for professional's personal well-being, their professional identity, and their engagement with clients. Social connection and self-care were strong protective factors against burnout; in particular seeking support from managers, supervisors, and colleagues. This research brings attention to systematic issues within the public sector that contribute to burnout and highlights a need for increased awareness and normalisation of burnout within workplaces.

Acknowledgements

I would like to extend my greatest thanks to the many people who helped me along this journey and made this research project possible. To my whānau, especially my mother and grandmother who have supported me in so many ways over the long course of my studies and, particularly the past two years of this project. To my partner, I am so grateful for your ongoing encouragement and positive spirits even when mine were low.

I would like to thank my supervisor Dr Armon Tamatea for supporting me in choosing a research project that I am passionate about and helping me turn my vision into a reality. Your expertise and guidance throughout this project has been invaluable and I have learnt a lot along the way.

I would also like to thank my peers in the Waikato clinical psychology programme, despite being busy themselves, they have been so generous with their time and energy and have provided me with advice and encouragement during this process.

Lastly, I would like to thank my participants for offering their valuable time to speak with me and sharing their honest experiences, some of which were difficult to share. I am so grateful and privileged to be able to listen to your stories and share them through this research.

Table of Contents

List of Figures

Introduction

> "Ready or not, we can't ignore the urgency; we are in a burnout epidemic. I say it's time, as we witness this illness overcoming workplaces around the globe, to rethink burnout" (Moss, 2021, p. 2).

Burnout is a negative psychological state of physical, mental, and emotional exhaustion that occurs from ongoing and intense occupational stress that many professionals face (Maslach & Leiter, 2017). Burnout can be a significant problem for both employees and workplaces; negatively impacting professional's mental and physical health (Ahola et al., 2008; Maslach & Leiter, 2017; Salvagioni et al., 2017), and professional identity (Hammond et al., 2018; Vivolo et al., 2022). Burnout has also been linked to poorer client outcomes (Hall, 2001; Salyers et al., 2015), reduced job satisfaction, and turnover (Johnson et al., 2018), which further worsens client waitlists and increases pressure on existing psychologists, ultimately perpetuating the burnout cycle (Every-Palmer et al., 2024).

Mental health workers are particularly vulnerable to experiencing burnout due to the demands of high-needs clients and the lack of resources within the public sector (EveryPalmer et al., 2024; Fischer et al., 2007; Kumar et al., 2011). Although many quantitative studies globally document the prevalence of burnout, there is little qualitative evidence conveying psychologists' true experiences of burnout in a New Zealand context. Therefore, this study will explore the experiences and causes, consequences, and coping strategies of burnout among psychologists in New Zealand using a thematic analysis approach. This study aims to increase awareness, help normalise burnout, and encourage others with similar struggles to seek help.

This literature review will provide an overview of burnout including its conceptual history, measurement, and clinical context. The current prevalence and risk factors for

developing burnout will be discussed. This chapter will examine the causes, consequences, and protective factors for burnout. Lastly, the public health sector in New Zealand, including staffing shortages, will be discussed.

Historical Conceptualisation

Research supporting the link between stress and poor health outcomes began in the early 1900s and was viewed as a cause of a number of physiological diseases (Cooper & Campbell Quick, 2017). This link continues to be prevalent in today's literature, as stress has been known to cause and worsen many chronic health conditions, some of which include cardiovascular diseases, cancers, and strokes (Cooper & Campbell Quick, 2017). During the 1960s/1970s, researchers began identifying stress as a psychological concept rather than solely a physiological concept. During this time a scholar in the field Lazarus (1966) introduced the idea that stress is not experienced objectively by individuals in the same way, instead stress impacts people differently depending on their personal characteristics. Lazarus defined psychological stress as a relationship between the person and the environment; where the individual predicts they have insufficient resources to cope with a situation thus becoming a 'threat'. To explain this concept he created the transactional model of stress which shows the relationship between the individual, their environment, and their own cognitive perceptions (Lazarus., 1966).

During the 1970's the concept of "stress" evolved with psychiatrist Freudenberger (1974) introducing the term "burnout" to describe a specific type of stress in the workplace. He defined burnout as a syndrome where employees failed to meet the demands of the job due to extreme exhaustion presenting as both physical and behavioural symptoms. Freudenberger explained how those working in nonprofit agencies, therapeutic clinics, and crisis support experience double pressure both internally and externally; internally due to the

empathetic and kind personalities employees hold, and externally from the large number of individuals who need support. These pressures cause many employees to overwork themselves and burn out (Freudenberger, 1974).

Simultaneously, during this time American psychologist Christina Maslach began publishing her first of many research articles on burnout. She began by investigating the emotional responses of workers in the social service sector. She interviewed a range of professionals working in human services such as medical staff, childcare workers, lawyers, and social workers and found that many had shared experiences of emotional depletion, negative feelings, cynicism, detachment, and a lack of empathy for their clients, which negatively impacted the level of care clients received (Maslach, 1976).

Following this, the term "burnout' quickly became popular on a global level, with many professionals using it to describe their work experience. During the 1980s – 1990s burnout research had reached Eurasia, The Middle East, America, and Australasia, followed by Africa, India, and China (Schaufeli et al., 2009). However, despite the term being widely used across cultures, there is not one consistent shared definition of burnout and this continues to be debated over time by different researchers (Desart & Witte, 2019; Maslach et al., 2001; Maslach & Leiter, 2017). During the early research, burnout was labelled 'unidimensional', as a severe form of exhaustion (Freudenberger, 1974; Pines & Aronson 1988). However, Maslach introduced burnout as 'multidimensional' when she discovered those working in helping professions showed a change in their relationship with their work and clients. This definition differentiated burnout from just severe 'exhaustion' or 'stress' and defined it as "A psychological syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who work with other people in some capacity" (Maslach, 1993, p. 20); Emotional exhaustion includes having low

energy, feeling worn out, and fatigued; Depersonalisation is feeling cynical, emotionally detached from others, having negative thoughts or attitudes, feeling withdrawn, and feeling unempathetic; A lack of accomplishment involves working less efficiently, losing motivation or morale, and struggling to cope with work (Maslach & Jackson, 1981).

This multidimensional definition is the most commonly used definition today, however, since the late 1900s, many researchers have created new definitions of burnout usually encompassing similar concepts to that of Maslach (1993). A systematic review of 192 studies across 45 different counties found there were 142 different definitions for meeting burnout criteria (Rotenstein et al., 2018) which illustrates the large variety in conceptualisation.

Measurement

As burnout has many overlapping symptoms with stress, physical ailments, and other mental health conditions, creating a measurement criterion was important for distinguishing its presentation from other conditions and being able to estimate prevalence rates in society (Edú-Valsania et al., 2022). Following the first measure that was created in 1981 (Maslach & Jackson, 1981) there have been numerous self-report measures created, critiqued, and adapted to reflect different conceptualisations of burnout, even today there is still not one agreed upon standard measure. Over time burnout measures have continued to be self-reported, researchers have suggested that going beyond self-report measures and incorporating more diverse methods could identify burnout more accurately among individuals. For example, examining biological markers such as increased cortisol levels (Edú-Valsania et al., 2022).

The Maslach Burnout Inventory (MBI) is the most commonly used and considered the ‘gold standard’ for measuring burnout (Shoman et al., 2021). This measure was created by Christina Maslach in 1981 and was derived from her multidimensional definition of burnout.

It measures emotional exhaustion, depersonalisation, and lack of accomplishment using 47 items ranging from zero to seven; lower scores reflect little or no burnout and higher scores reflect more severe burnout (Maslach & Jackson, 1981).

Despite the MBI's strong empirical evidence proving its validity and reliability, it has been widely critiqued over the years revealing many limitations. Its standardisation sample was predominantly Caucasian (89%) and tertiary educated (67%) therefore, it may not be a suitable measurement for ethnic minorities and those without tertiary qualifications (Maslach & Jackson, 1981). Additionally, the MBI is only applicable to human service occupations, despite evidence that burnout occurs beyond human service professions (Demerouti et al., 2001; Demerouti & Bakker, 2007). To address this limitation modified versions of the MBI were created 15 years later for use in specific occupations such as the MBI-ES for educational settings (Maslach, 1996), the MBI-HSS for healthcare settings (Maslach, 1996), and the MBI General Survey (MBI-GS) for use across all occupations (Schaufeli et al., 1996). The MBI-GS has since been widely validated across counties and professions (EdúValsania et al., 2022; Schutte et al., 2000).

Another critique of the MBI was that the psychometric items of each dimension were biasedly framed. The items measuring emotional exhaustion and depersonalisation were all framed negatively whereas personal accomplishment items were all framed positively. To address this Demerouti and colleagues created the OLdenburg Burnout Inventory (OLBI) in 1999 which had a mixture of positively and negatively framed items within the dimensions, as well as applying to non-human-service professions (Demerouti, 1999). Although the OLBI was created in Germany on German participants, when translated to English it was found to be a reliable and valid alternative to the MBI for English speakers (Halbesleben & Demerouti, 2005).

Six years later, in 2005, the Copenhagen Burnout Inventory (CBI) was created to measure personal burnout, client-related burnout, and work-related burnout (Kristensen et al., 2005). The CBI addressed some of the limitations of the MBI; similarly to other researchers (Halbesleben & Demerouti, 2005; Schutte et al., 2000) they argue that personal accomplishment should not be included in the measure because it is a consequence of burnout rather than a specific domain. Instead the CBI focuses on fatigue and exhaustion as the core components, consistent with the unidimensional view of burnout by Pines and Aronson (1988). They also criticised how questions in the MBI caused angry and emotional reactions from respondents due to the negative wording. To address this criticism, they adopted more neutral questions in the CBI. Studies suggest the CBI has good validity and reliability for helping professions across cultures (Kristensen et al., 2005; Montgomery et al., 2021; Shoman et al., 2021) and when compared, has comparable psychometric properties to the MBI (Ogunsuji et al., 2022; Winwood & Winefield, 2004).

Many adapted measures for burnout have been created over the past 43 years with some using existing dimensions of burnout such as the Burnout Assessment Tool (BAT) that measures exhaustion, cognitive and emotional impairments, and mental distance (Schaufeli et al., 2020) and others incorporating entirely new dimensions of burnout, for example, the Spanish Burnout Inventory (SBI) that measures guilt, interpersonal strain, and enthusiasm (Figueiredo-Ferraz et al., 2013). However; the MBI still remains the most common measure today (Edú-Valsania et al., 2022; Figueiredo et al., 2024) despite its many critiques by researchers (Demerouti et al., 2001; Demerouti & Bakker, 2007; Halbesleben & Demerouti, 2005; Kristensen et al., 2005; Schutte et al., 2000). Nonetheless, there is a long way to go in terms of validating the abundance of existing burnout measures across cultures and creating a concurred threshold for a clinical diagnosis (Edú-Valsania et al., 2022; Figueiredo et al., 2024; Shoman et al., 2021).

Clinical Significance

The lack of a consistent conceptualisation of burnout has implications for its clinical significance. Burnout is not taken as seriously as other clinical disorders in many contexts and relates to the lack of empirically supported evidence-based treatments for burnout specifically (Maslach & Schaufeli, 2018; Dam, 2021). Over-time research has proven that burnout is more than just stress and has significant negative implications for professionals, their clients, and organisations (Lu et al., 2020; Salyers et al., 2015; Stone et al., 2021; Zarei et al., 2019), however, because the term 'burnout' is used so broadly, it can be conceptualised differently across different professions/contexts. For example, from a psychological view burnout can cause severe mental health deterioration such as anxiety and depressive symptoms (Ahola et al., 2005), and disrupt one's identity and self-esteem (Hammond et al., 2018; Vivolo et al., 2022). From a medical perspective burnout can lead to physical ailments such as cardiovascular diseases and HPA axis dysregulation as well as reduced cognitive abilities (Kakiashvili et al., 2013). From an organisational view, burnout can be viewed as an occupational issue that can lead to reduced professional efficacy (Hall, 2001; Salyers et al., 2015), absenteeism, and turnover (Johnson et al., 2018).

In New Zealand, similarly to most other countries, burnout is considered a psychological disorder, not a clinical diagnosis. Despite having some overlapping symptoms with other formal DSM diagnoses such as anxiety, depression, stress disorder, and mood disorders, burnout is not a clinically recognised disorder under the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (Schaufeli et al., 2009). However, in Scandinavia burnout is considered a clinical disorder as it is recognised in the International Classification of Diseases 11th revision (ICD-11) as an occupational syndrome that occurs from "chronic workplace stress that has not been successfully managed (World Health Organisation, 2019). This implies burnout is considered more serious in Scandinavia and individuals are offered

compensation and specified treatment when formally diagnosed. Netherlands researcher Dam Arno (2021) has provided a clinical perspective of burnout which defines it as resulting from chronic long-term stress, while providing recommended phases of treatment specific to burnout.

The question of whether burnout should be considered a formal disorder is an ongoing debate across the literature (Maslach & Leiter, 2017; Schaufeli et al., 2009) and the conceptualisations around burnout continue to change over time with new researchers challenging old definitions and proposing changes (Desart & Witte, 2019; Kakiashvili et al., 2013; Dam, 2021).

Prevalence

Research shows that burnout is prevalent across many countries, cultures, and occupations (Schaufeli, 2017). However, despite being widely researched, the prevalence of burnout differs across studies due to inconsistent definitions of burnout as described above and common methodological issues across research including small sample sizes, differing cut-off scores, bivariate analyses over multivariate analyses, and a lack of longitudinal studies (Morse et al., 2012). A large systematic review of 192 studies across 45 different counties found a 67% prevalence rate of overall burnout. They also found that there were 142 different definitions for meeting burnout criteria, showing how the varied conceptualisation of burnout can alter prevalence rates (Rotenstein et al., 2018).

Research suggests that the prevalence of burnout among mental health professionals is high with some studies showing over 50% of professionals experience burnout in the public sector (Akova et al., 2022; Chambers et al., 2016; Lu et al., 2020; Nicholls et al., 2021; Stone et al., 2021; Zarei et al., 2019). In particular psychologists (Blayney & Kercher, 2023;

McCormack et al., 2018) and psychotherapists (Simionato & Simpson, 2018) are known to experience high levels of burnout within helping professions. This is likely due to the combination of both internal factors such as the challenging nature of working with people, and external factors of working within the constraints of the public sector (Maslach & Schaufeli, 2018; Schaufeli et al., 2009).

Risk Factors

Despite varied burnout prevalence rates, there are documented risk factors that can make professionals more vulnerable to developing burnout, meaning the prevalence of burnout can differ across subgroups such as occupation, working in the public sector, the severity of patients, age, sex, and personality type.

Occupation

Despite early beliefs that burnout was exclusive to human service workers, studies show that burnout can exist within many different professions and roles (Maslach et al., 2001). However, the majority of the research on burnout continues to be conducted within human service industries, in particular, healthcare practitioners such as general practitioners, nurses, mental health workers (those who work in the mental health industry such as psychologists, mental health nurses, counsellors, psychiatrists), medical students, and other physicians (Hall et al., 2020; McCormack et al., 2018; Parandeh et al., 2022; Rotenstein et al., 2018; Yang & Hayes, 2020). A narrative review of burnout among mental healthcare staff suggests that staff face many systematic challenges such as inadequate staffing, excessive workload, poor leadership, a lack of support, and underfunding. As well as many patientlevel challenges such as high levels of violence, treating patients who refuse care, and working with high-risk individuals. A mixture of all of these factors likely contributes to the prevalence of burnout for mental health workers (Johnson et al., 2018). No studies have

compared rates of burnout across occupations (Morse et al., 2012) therefore, we cannot be certain that those in the medical field suffer from burnout more than those in other occupations.

Public Sector

Research suggests that working in the public sector is a risk factor for developing burnout (McCormack et al., 2018; Stone et al., 2021). A study conducted in China comparing public and private health facilities found that the public health group had a 10% higher burnout rate than the private group; and had higher rates of each subgroup (reduced personal accomplishment, emotional exhaustion, and depersonalisation). However, it is important to acknowledge both rates of burnout were quite high (58.06% for public and 47.55% for private) (Lu et al., 2020). Furthermore, two studies of practising psychologists found that those practising privately had less emotional exhaustion (Rupert & Kent, 2007) and depersonalisation, and more personal accomplishment than those practising in public sectors (Ackerley et al., 1988). Possible reasons why private psychologists may experience less burnout is because they are typically older and more experienced, earn a higher wage, report being less stressed and have more autonomy in their work – leading to greater satisfaction and personal accomplishment (Ackerley et al., 1988; Hellman & Morrison, 1987; Maslach & Leiter, 2016; Rupert & Kent, 2007; Vredenburgh et al., 1999). On the other hand, private psychologists do report having less professional support and have a higher risk of becoming overinvolved with their clients which are both predictors of burnout (McCormack et al., 2018; Rupert & Kent, 2007).

Severity of Patients

Studies also found that the severity of patients varies between private and public psychologists, which may impact their risk of burnout. Public psychologists often do not have

control over the severity of their clients whereas private psychologists do. Private psychologists were found to be less burnt out and typically treated clients with interpersonal issues, whereas public psychologists typically treated clients with substance abuse issues, psychotic behaviour, and personality disorders (Ackerley et al., 1988). Similarly, another study that compared public and private psychologists found that public psychologists who were treating patients with severe psychosis or personality disorders were more stressed, and experienced greater self-doubt, and personal depletion (Hellman & Morrison, 1987).

Age

Although burnout is known to occur after a prolonged period, many researchers have debated whether professionals' age and experience impact the risk of developing burnout (McCormack et al., 2018). Some studies claim that burnout is less common among older, more experienced professionals because they have acquired the skills to manage and prevent burnout over time and are more competent in enforcing work/life boundaries (Lim et al., 2010; Maslach & Leiter, 2017; McCormack et al., 2018; Yang & Hayes, 2020). A New Zealand study that looked at public health workers across 20 District Health Boards (DHB) found burnout decreased with age. However, those in their 30s had the highest prevalence of personal burnout (not work-related); this could be attributed to having a busy home life parenting children (Chambers & Frampton, 2022).

Conflictingly, other researchers state that one's risk of burnout increases with age due to being exposed to ongoing organisational stress over their career (Ahola et al., 2006; Maslach et al., 2001). The issue of survival bias should be considered with age studies, that is the idea that younger professionals may have burnt out early in their career and quit, leaving those who are less prone to burnout to remain in the profession (Chambers & Frampton, 2022; Maslach et al., 2001; Maslach & Leiter, 2016).

Sex

Similarly to age, sex is another factor that has been widely debated across burnout studies lacking a clear trend (Maslach & Leiter, 2017). A systemic review revealed women may be particularly vulnerable to developing burnout (Yang & Hayes, 2020). A New Zealand study of public health professionals found women were 15.5% more likely to have high personal burnout and 7.9% more likely to have work-related burnout than men (Chambers et al., 2016). Conflictingly, two systematic reviews reported that there is inconclusive evidence that one gender is more vulnerable to burnout (McCormack et al., 2018; Rotenstein et al., 2018). Despite the research gap around transgender and nonbinary individuals experiencing burnout (Yang & Hayes, 2020) one study found they had the highest levels of burnout compared to cis male/females (Nicholls et al., 2021).

Some studies have found gender differences between different aspects of burnout. Many studies state females have higher emotional exhaustion than males (Maslach & Leiter, 2017; Parandeh et al., 2022; Purvanova & Muros, 2010), while males are believed to experience more cynicism (Maslach & Leiter, 2017) and depersonalisation (Purvanova & Muros, 2010; Rupert & Kent, 2007; Vredenburgh et al., 1999).

Response bias may explain why women seem to be more burnt out than men, because women are more likely to report they are burnt out compared to men (Purvanova & Muros, 2010). There are also more women participating in research, when looking at the samples of many studies (Hall, 2001; Nicholls et al., 2021; Stone et al., 2021; Zarei et al., 2019), this is possibly because women dominate most caring professions (psychologists, social workers, teachers, nurses) and the impact of this is the difficulty in obtaining a thorough representation of males opinions through the literature (Innstrand et al., 2011).

Personality

Research has found that personality can impact one's vulnerability to burnout due to the way they respond to and cope with stress (Maslach & Leiter, 2017). Those higher in neuroticism and lower in agreeableness, extraversion, and openness are more likely to experience burnout (Maslach et al., 2001; Maslach & Leiter, 2017; Schaufeli & Enzmann, 2020; Swider & Zimmerman, 2010), with some suggesting neuroticism is the strongest predictor of burnout due to individuals being emotionally dysregulated, hostile, anxious, selfconscious, and easily distressed (Schaufeli & Enzmann, 2020). The psychology profession is known to be common amongst those with type A personalities, which has also been linked to the burnout aspects of low personal accomplishment (Alarcon et al., 2009) and exhaustion (Maslach 2001).

Causes of Burnout

Risk factors can enhance one's likelihood of developing burnout, whereas causes are often directly linked to burnout; burnout can be caused by a combination of factors acting over a prolonged period of time. The main contributors to burnout are often systemic issues such as high workload, limited resources, a lack of autonomy, and an unsupportive environment (Coates & Howe, 2015; Kumar et al., 2011; Vivolo et al., 2022). Another potential cause of burnout for mental health professionals, in particular, is the emotional strain caused by recurrent exposure to traumatic material in their day-to-day work. This emotional consequence can be described as compassion fatigue, secondary traumatic stress, or vicarious trauma which can all contribute to burnout (McCann & Pearlman, 1990; Temitope & Williams, 2015).

Understaffing and Workload

High workload, understaffing, and a lack of autonomy are all strong predictors of burnout and they are often all linked together. This is because the demand for mental health support is larger than available psychologists, this results in high workloads and long waitlists creating pressure for psychologists to work faster to treat more clients (Every-Palmer et al., 2024). For psychologists to see more clients in a shorter amount of time, they may have to sacrifice their quality of work which could limit their autonomy to practice in the way they ethically see fit. This process is explained by the Demand-Control Model created by Karasek (1979) which states burnout occurs from high demands and lack of control over decision making. As clinicians begin to burn out and leave the workforce, this additional strain puts existing staff at a higher risk of burnout, creating a cycle and further perpetuating the staffing issue in New Zealand's mental health sector (Chambers & Frampton, 2022; Every-Palmer et al., 2024).

The understaffing of mental health clinicians is a significant issue in New Zealand (Chambers & Frampton, 2022). A New Zealand study looked at 540 psychiatrists' opinions of the current mental health sector and found that 60% of participants reported staffing in their workplace had decreased. This shortage put extra pressure on existing staff to work more, often impeding into their personal time, with 90% of participants reporting that their after-hours work had increased due to high workloads and demand from patients (EveryPalmer et al., 2024).

Staffing and resource shortages weigh heavily on the emotions of clinicians whose purpose is to help people. In a New Zealand study with psychologists, participants spoke about the guilt they felt from not being able to provide for clients because of the limited resources within the sector and how this drove them to work overtime (Blayney & Kercher,

2023). Clinicians describe not being able to provide clients with solution as “soul-destroying”; 98% stated that often individuals who needed specialised treatment were not able to access adequate care due to insufficient resources within the workplace. (Every-Palmer et al., 2024).

Another issue clinicians raised was their high workload due to having to do multiple jobs within the psychologist role such as administration or case management (Every-Palmer et al., 2024). Many clinicians reported that having high admin responsibilities meant they had less time for clinical or client work and was a waste of their skill set (Blayney & Kercher, 2023; Fischer et al., 2007; Vivolo et al., 2022).

Lack of Autonomy

Research shows that a lack of autonomy within the workplace can increase the risk of burnout (Maslach et al., 2001; Maslach & Leiter, 2016; McCormack et al., 2018; Vivolo et al., 2022; Yang & Hayes, 2020). Job autonomy refers to the flexibility a clinician has to make decisions regarding their work and access to resources that allow them to work in a way that is ethically best for their client (Maslach et al., 2001). Many public psychologists face a lack of autonomy in their role due to having to meet high organisational targets with limited resources, and this conflict between meeting the needs of the workplace versus meeting the needs of their clients creates an ethical dilemma that can be very distressing for clinicians (Maslach et al., 2001; Vivolo et al., 2022). In the article by Blayney and Kercher (2023), psychologists reported that a lack of autonomy over their work contributed to their burnout because they hold a huge amount of responsibility with no ability to make changes. One participant spoke about how their workplace adopted a medicalised model which caused them to be more focused on numbers and targets rather than person-centered care. A Canadian study questioned 597 health professionals and found that when clinicians had managers who gave them autonomy over their work they had higher work satisfaction and well-being, they

reported having lower distress levels and being less likely to leave their jobs (Moreau & Mageau, 2012).

A consequence of the lack of autonomy within public sector organisations is that it may drive clinicians into the private sector which worsens the existing staff issue that the public health sector is facing (Every-Palmer et al., 2024). Research suggests that private clinicians have more control over their hours, client numbers, and administrative responsibilities, leading to higher job satisfaction and personal accomplishment (Ackerley et al., 1988; Hellman & Morrison, 1987; McCormack et al., 2018; Rupert & Kent, 2007).

Unsupportive Work Environment

Research shows that working in an unsupportive environment can exacerbate burnout among professionals. Mental health workers in the public sector are subject to high-stress environments; having the support of colleagues, managers, and supervisors can help workers manage this stress before it becomes critical (Maslach & Leiter, 2016, 2017; Vivolo et al., 2022). A supportive work environment refers to feeling supported by your managers, supervisors, and colleagues and is important for cohesion in the workplace and maintaining happy and efficient employees (Fischer et al., 2007). Psychiatrists from a New Zealand study reported that feeling undervalued at work contributed to their burnout, they described management as having a lack of respect and understanding of the role of a psychologist while expecting them to fulfil expectations from other roles such as a case manager, social worker, and nurse (Blayney & Kercher, 2023)

Traumatic Client Content

Psychologists and mental health professionals are typically exposed to traumatic content through their client work, which over time can lead to compassion fatigue, secondary

traumatic distress, and vicarious trauma; often associated with the depersonalisation aspect of burnout (McCann & Pearlman, 1990).

Research shows that it is common that exposure to traumatic material can manifest in the personal and professional lives of mental health clinicians (Ilife & Steed, 2000; McCann & Pearlman, 1990; Steed & Downing, 1998). Studies have found clinicians commonly experience disruptions in their own schemas about themselves, the world, and others. For example, in two studies, mental health clinicians who had worked in the space of sexual abuse and domestic violence commonly reported experiencing increased hypervigilance about potential threats, wariness around men, felt more cynical and struggled to trust others (Ilife & Steed, 2000; Steed & Downing, 1998). These studies also found it was common for participants to experience intrusive symptoms such as dreams, imagery, or unwanted thoughts (Steed & Downing, 1998). On the other hand, some research states that evidence for vicarious trauma is lacking and points out the frequent methodological issues among studies that show a correlation between exposure to trauma and vicarious distress, they state more research needs to be done in the area of vicarious trauma among mental health workers (Devilly et al., 2009; Sabin-Farrell & Turpin, 2003).

Although there is limited research that investigates the causal relationship between vicarious trauma and burnout (Ilife & Steed, 2000; McCann & Pearlman, 1990; Temitope & Williams, 2015), some studies believe exposure to trauma or STS causes burnout. In the article by Ilife and Steed (2000) 12 out of the 18 participants reported feeling burnt out due to working in the domestic violence space and being exposed to the traumatic content from clients. On the other hand, others believe secondary traumatic stress is a consequence following burnout. As discovered by Temitope and Williams (2015) burnout predicted secondary traumatic stress and explained how professionals who are burnt out have less

energy, time, and coping mechanisms leaving them vulnerable to developing secondary traumatic stress. They also explained that when experiencing burnout and secondary traumatic stress, individuals are more likely to go onto develop compassion fatigue.

Consequences of Burnout

Burnout can impact the personal and professional lives of psychologists creating ongoing negative consequences for them and their clients. At a personal level burnout is associated with psychological distress and poor well-being, including disorders such as anxiety and depression (Akova et al., 2022; Maslach & Leiter, 2017; Stone et al., 2021), which can in turn lead to physical symptoms and illnesses (Maslach & Leiter, 2017; Salvagioni et al., 2017). At a professional level burnout can impact the quality of care provided to patients, and lead to increased absenteeism, and staff turnover (Johnson et al., 2018).

Emotional Wellbeing

There is no denying that burnout negatively affects clinicians' mental health and wellbeing. Despite being a distinct concept, burnout has many overlapping symptoms with depression such as hopelessness, anhedonia, sleep disturbances, fatigue, negative feelings, and concentration struggles (Bianchi et al., 2015). A Finland study on over 3000 employees found that 50% of employees with severe burnout met the DSM-IV criteria for a depressive disorder (Ahola et al., 2005). Similarly, A US study on public health care professionals found out of 225 workers, 66.2% suffered from burnout, 41% had anxiety symptoms and 29.1% had depressive symptoms. Qualitative studies on burnout show clinicians speaking about crying frequently at work (Blayney & Kercher, 2023; Kumar et al., 2011) and having negative thoughts about themselves and their abilities such as feeling like a failure (Hammond et al., 2018; Vivolo et al., 2022).

Physical Wellbeing

Research states that emotional exhaustion is the most commonly reported burnout symptom (McCormack et al., 2018; O'Connor et al., 2018), which combined with stress can lead to physical health conditions. Conditions such as cardiovascular diseases, gastrointestinal issues, headaches, respiratory issues, insomnia, muscle pain, and high cholesterol-related disorders have all been correlated with burnout (Maslach & Leiter, 2017; Salvagioni et al., 2017). A cross-sectional study in Finland compared individuals with and without burnout, those with burnout had a 10% higher presence of physical illness and participants' physical health declined as their severity of burnout increased. Additionally, researchers found significant links between cardiovascular diseases among men and musculoskeletal diseases among women (Honkonen et al., 2006). The link between burnout and physical health conditions is widely supported across studies. The cause of this link is not certain, however, can be explained by impairments in multiple biological processes such as metabolic, hypothalamic-pituitary-adrenal axis dysregulation, sympathetic nervous system, inflammation, immunity, blood flow, and health behaviours. This shows how the extent of burnout goes beyond psychological distress and should perhaps be targeted at a physiological level as well (Melamed et al., 2006).

Quality of Care

At a professional level burnout can impact the quality and amount of care professionals can provide their clients (Hall, 2001; Salyers et al., 2015). A study on general practitioners found that burnout affected both the quality of care to patients and patient safety. Burnt-out general practitioners felt they showed less empathy, poorer listening skills, rushed consultations and alleviated responsibility by referring to other services when at times were inappropriate. General practitioners admitted that this may lead to missed and wrong diagnoses and prescriptions for patients (Hall, 2001). Similarly, A study of 123 clinicians

found that 58% felt their burnout negatively impacted the quality or output of their work despite their best efforts to prioritise the client. One participant spoke about the harmfulness of having high turnover due to clients having to move on to another clinician after building a trusting relationship with them, this impacts the therapeutic relationship while reducing client satisfaction (Salyers et al., 2015). As well as reduced quality of care, burnout is also known to impact productivity at work; a systematic review of nurse burnout found those with higher emotional exhaustion showed significantly lower productivity at work (Jun et al., 2021).

Sick Leave and Turnover

Burnout has also been linked to increased time off and sick leave, and if left unaddressed could result in resignation, adding to already high turnover rates within the public sector. Research has shown those with burnout take more sick leave; A Finnish study found that incidences of sick leave with a medical certificate were higher among those who were burnt out compared to those who were not burnt out (Ahola et al., 2008). Additionally, research has shown that healthcare workers in the public sector take double the amount of sick leave compared to those working in the private sector (Johnson et al., 2018). Although increased stress has been linked to physical illness (Salvagioni et al., 2017), it is also becoming more common for professionals to take sick leave for psychological reasons such as anxiety, depression, and mental fatigue (Johnson et al., 2018).

Burnout has been linked to poor job satisfaction and higher staff turnover (Johnson et al., 2018). In an American study of 460 mental health care professionals, where over half had moderate-high emotional exhaustion, 50% were considering quitting their jobs (Acker, 2012). In a New Zealand study on 368 DHB psychiatrists, where just over a third were burnt out, 45% expressed wanting to leave their job, with a theme being that clinicians enjoyed their clinical duties but struggled with the high demands and resource shortages (Chambers &

Frampton, 2022). A consequence of the high turnover rates within the public sector is that they have to recruit and train new staff which is costly, time-consuming, and resourcedepleting which can lead to reduced quality of care for current patients (Johnson et al., 2018).

Coping Strategies and Interventions

Despite the majority of the burnout research focusing on the prevalence instead of interventions, many modes of treatment are useful in improving and preventing burnout (Hätinen et al., 2009; Leiter & Maslach, 2018; Vivolo et al., 2022). Interventions for burnout can either be implemented at a personal level or an organisational level (Maslach & Goldberg, 1998). The research remains mixed on whether individual level, organisational level, or a mixture of the two are more effective at reducing burnout. However, evidence suggests that any intervention, despite the level, helps reduce burnout (Dreison et al., 2018; Morse et al., 2012).

Individual Level Interventions

Individual-level interventions are the most commonly recommended approach to improving burnout (Leiter & Maslach, 2018; Maslach & Goldberg, 1998). They focus on providing the person with coping strategies around how to manage their stress and improve their wellbeing, this idea assumes that burnout occurs from an individual's inability to cope with workplace stressors in their environment (Maslach & Goldberg, 1998).

Many individual-level interventions often entail self-care practices as it is believed that keeping one's mind and body healthy makes them better equipped to handle challenges such as burnout (Maslach, 2017), examples include exercising, seeking social support, maintaining workplace boundaries, and engaging in hobbies. Research suggests exercise reduces depressive and anxiety symptoms, helps prevent many physical health conditions,

and improves one's quality of life (Schmitz et al., 2004). A randomised control trial conducted in Australia found that employed individuals with high levels of burnout decreased by over half (37.6% to 14.9%) after participating in four weeks of exercise. Researchers also found a significant improvement in stress, emotional exhaustion, and personal accomplishment amongst participants (Bretland & Thorsteinsson, 2015).

Another self-care strategy for improving burnout is connecting with loved ones which is proven to reduce stress and improve wellbeing (Hamaideh, 2011; Maslach, 2017; Maslach & Goldberg, 1998). Social connection is a basic human need and can help with emotional regulation, decision-making, and companionship. A study with physicians found those who spent more quality time with their family and friends were less exhausted and more engaged in their work lives (Li et al., 2023).

Maintaining workplace boundaries and making time for hobbies has been found to reduce burnout (Maslach & Goldberg, 1998; Morse et al., 2012). A US study on over 3000 physicians found that 84.3% of participants reported that engaging in hobbies outside of work reduced stress and exhaustion (Li et al., 2023). Additionally, a New Zealand study on burnout among psychiatrists found engaging in hobbies and prioritising their personal interests were strong protective factors against burnout (Fischer et al., 2007). With high work pressures, many professionals fall victim to working overtime, however, establishing firm boundaries between work and home was a strong protective factor for many psychologists (Blayney & Kercher, 2023).

Cognitive behavioural therapy (CBT) strategies such as stress management skills, mindfulness, or relaxation skills has proven to be effective in improving burnout (Maslach et al., 2001). A longitudinal study looked at the impact of CBT on those on sick leave due to

burnout, the study found those who attended weekly sessions for nine to 13 weeks showed increased confidence in managing their burnout which resulted in their symptoms decreasing. Additionally, researchers found that CBT significantly improved sleep quality which can be a causal and maintaining mechanism of burnout (Santoft et al., 2019). A metanalysis of 22 studies on therapeutic interventions for burnout shows all three of the studies that used CBT saw a significant reduction in burnout despite the length of therapy (one to six months), in one study positive results continued up to a year later (Jaworska-Burzyńska et al., 2016). Many psychologists recognise that they have the skills to improve their burnout, however, forget to practice what they preach when it comes to applying CBT strategies in their own life (Blayney & Kercher, 2023).

Despite individual-level interventions being the most commonly recommended, they hold some limitations. It can be difficult for individuals to focus on their recovery and implement their own strategies when they are already exhausted. It also disregards the workplace environment's potential role in causing individual burnout, meaning no change is made to the root cause of the burnout (Hätinen et al., 2009; Maslach, 2017).

Organisational Level Interventions

Organisational level interventions focus on the systemic issues within the workplace that may be contributing to burnout. Organisational strategies may involve providing more opportunities for supervision, increasing managerial awareness and understanding of burnout, prioritising role autonomy and flexibility, team bonding techniques to improve cohesion between colleagues, decreasing workloads, and increasing resourcing (Morse et al., 2012).

Improving the awareness of burnout within the workplace can be the first step to supporting those who are at risk of burning out. Many practitioners have spoken about the importance of managerial, supervisory, and collegial support for reducing burnout (Fischer et

al., 2007; Vivolo et al., 2022). Having positive relationships with colleagues has been linked to better job satisfaction, lower turnout rates, and improved exhaustion levels and personal accomplishment which are all factors that protect against burnout (Ducharme et al., 2007; Fernet et al., 2010; Yang & Hayes, 2020). A study on mental health workers found that speaking with colleagues was the most common coping method at work. Participants spoke about how the informality of unpacking stressful events and receiving support and guidance from colleagues was hugely beneficial (Reid et al., 2014). Having adequate supervision is another important part of preventing burnout (Vivolo et al., 2022; Yang & Hayes, 2020). According to Yanchus et al (2017) having understanding supervisors increased job satisfaction and reduced the likelihood of quitting for mental health professionals. Many individuals who experience burnout suffer from feelings of self-doubt and inadequacy as practitioners, supervision can help professionals navigate this. A study of 49 physicians in the Waikato and Bay of Plenty area showed that support within the workplace was important for their clinical competency regarding responding to mistakes, especially for those who were experiencing emotional exhaustion as they were more likely to struggle with self-doubt and self-blame. Of participants 70% reported needing support following mistakes, 72% reported needing to talk to someone about their mistakes, and 74% reported needing validation around their decisions (Bruce et al., 2005).

Some studies suggest that burnout is best addressed at an organisational level (Hätinen et al., 2009; Maslach, 2017). A meta-analysis of 19 articles looked at the efficacy of burnout reduction interventions for physicians. They looked at individual-level interventions (CBT techniques, mindfulness strategies, stress reduction techniques, and education) as well as organisational-level interventions (changes to the working environment, reducing workload, and optimising internal systems). They found that organisational-level interventions were significantly more effective in improving burnout compared to individuallevel interventions

(Panagioti et al., 2017). Despite the evidence that organisational-level interventions are most efficient in reducing burnout, they are not typically adopted by workplaces because they require more effort, time, and resources from the workplace than individual interventions (Maslach et al., 2001).

Combined Interventions

Some research suggests interventions that adopt a combined approach of targeting both the individual and the organisation are most likely to improve burnout (Maslach et al., 2001). A review of 25 quasi-experimental and randomised control trial studies found that 80% of interventions were effective in reducing burnout; they found that individual-level interventions were more effective at reducing burnout in the short term (zero to six months) whereas combined interventions reduced burnout in the long term (12+ months)(Awa et al., 2010). Another article analysed the efficiency of providing staff with a combined intervention, such as cognitive restructuring for managing emotions and training for managers on how to better support staff, this resulted in a decrease in depersonalisation but not emotional exhaustion or personal accomplishment (Scarnera et al., 2009).

Drawing from above, burnout is a complex condition that has evolved over time. The popularity of the term ‘burnout’ and the copious amounts of research on the topic suggests people are becoming more aware of this condition and ways to prevent it. The recent view of burnout as a clinical disorder in Scandinavia (World Health Organisation, 2019) gives hope that it is considered more serious than when it was first referred to as “pop psychology” in the 1980s (Schaufeli, 2003). However, it is still often viewed as a personal failure implying that public health systems and workplaces still need to take accountability for their part in contributing to the preventable condition (Hätinen et al., 2009; Maslach, 2017).

New Zealand Public Health System

New Zealand's public health system ensures that residents and citizens can access mental health support through community-based services that are government funded (Williams et al., 2017). The public mental health system is tiered by primary, secondary and tertiary mental health services. Primary mental health services include support at the community level such as general practitioners, counsellors, private psychologists, or social support services. They are designed to support individuals with mild to moderate mental health concerns. Most individuals suffering from mental health concerns are assessed and treated in the primary sector. Secondary services treat those suffering from severe mental illness and include access to publicly funded community mental health services such as psychologists, psychiatrists, and speech-language therapists. Tertiary services treat the most severe mental health cases at immediate risk and include inpatient services and crisis teams (Te Whatu Ora, 2020).

Many issues exist within the public health system which create challenges for mental health staff and barriers for patients. One issue is that due to limited resources and long waitlists, only those with severe mental health issues are treated urgently (the minority) and those suffering from mild to moderate mental health issues (the majority) or those at risk of developing serious mental health issues in future are pushed aside (Fitzgerald et al., 2009). This further perpetuates the high prevalence of mental health disorders in New Zealand (Williams et al., 2017). Another issue is the large amount of responsibility placed on the primary sector to screen for mental health issues and act as the gateway for support (Fitzgerald et al., 2009; Williams et al., 2017). There are many barriers such as cost and time that can deter individuals from visiting their general practitioner which can prevent them from receiving appropriate support (Lockett et al., 2018). Another issue with this system is that general practitioners are the first point of contact for those experiencing mental health

difficulties, however, they are not trained mental health professionals and have limited time with clients which can lead to engagement and triaging issues. A New Zealand study found that 44.7% of individuals with a year long history of suicide attempts did not seek professional help within the year, and less than a third only received psychiatric treatment after they attempted suicide (Beautrais et al., 2006).

Psychologists exist in a variety of settings across New Zealand including education, private practice, ACC, corrections, communities, Kaupapa Māori organisations, neuropsychology, and almost 50% work in the health sector (NZ College of Clinical Psychologists, 2016). The majority of the psychologists in the health sector are clinical psychologists and make up 53% of the total psychologist workforce in New Zealand (NZ College of Clinical Psychologists, 2016).

In New Zealand the demand for mental health support in the public health sector outweighs the available resources, causing long waitlists (Fischer et al., 2007; Kumar et al., 2011). The mental health status of New Zealanders continues to worsen over time especially for young people with statistics showing comparatively high youth suicide rates on a global level (Mulder et al., 2017) and a 73% increase in mental health and addiction service demand over the past 10 years (Health and Disability Commissioner, 2018).

Despite this growing need, the number of available psychologists continues to fall short. An annual 2023 report showed that 268 additional psychologists were needed in DHBs and 672 in the primary health sectors across New Zealand to meet the public demand. On average, primary care settings had one psychologist per 100,000 people and the estimated need to meet the demand was 15 psychologists per 100,000 people (New Zealand Psychologists Board., 2023). Although there is a clear need for more psychologists, the issue lies in the limited number of available places in accredited psychologist training programmes;

producing an estimated 50-60 new clinical psychologists each year (New Zealand Psychologists Board, 2023; Rucklidge et al., 2018). Although the number of registered psychologists is increasing over time by approximately 100 per year, this is not enough to match the demand in communities which further maintains long waitlists and high workloads, leading to burnout (Every-Palmer et al., 2024).

Current Study Aim and Objectives

Although burnout is widely studied, the majority of the research is quantitative and conducted outside of New Zealand. However, there are limited qualitative studies sharing psychologists' voices about their experiences of burnout and strategies that helped them recover. Therefore**,** this study aims to explore the experiences, consequences, and coping strategies of burnout among practising psychologists in New Zealand. Because there is a level of shameful stigma surrounding burnout, this analysis aims to shed light on the realities of experiencing burnout and show others who may have had similar experiences that they are not alone.

In this study, I will be addressing the following research questions:

1. What factors contribute to psychologists' burnout?
2. How does burnout impact both the personal and professional lives of psychologists through their own past experiences?
3. What are some coping strategies psychologists use to help them improve their burnout, and what precautions do they take to prevent it from occurring again?

Method

Analytical Reasoning

I chose to investigate psychologist's experiences of burnout from an experiential qualitative approach, which focuses on the participants' standpoint and how they experience and make sense of the world (Clarke & Braun, 2013). I chose this method to give psychologists' who are experiencing burnout a voice to share their views, validate their experiences, and in turn normalise and raise awareness around burnout. I believe rich data may have been missed through choosing a quantitate approach and wanted to hear about experiences from psychologists directly, without shaping or reducing their experiences down to fit into set survey questions. A lot of the current research on burnout is done quantitatively (Chambers et al., 2016; Chambers & Frampton, 2022; Coates & Howe, 2015; Nicholls et al., 2021; Surgenor et al., 2009; Temitope & Williams, 2015) and looks at the prevalence of burnout, it is well known that burnout exists among psychologists, however, I wanted to investigate beyond this by looking at the experiences, causes, and consequences of this burnout as well as the remedial strategies they used to recover.

I considered different qualitative methods before deciding to use a thematic analysis approach. A narrative approach, although is useful to analyse stories and experiences of individuals, I felt was not appropriate for my research questions. I was interested in the experiences of burnout during a period of time, rather than a chronological series of experiences that may have led to burnout. I was also mindful that narrative research can consist of multiple forms of data gathering and interviews over time, which would not have been suitable for my participant group given many of them were busy and had limited time to offer (Cresswell, 1999).

Interpretive phenomenological analysis, although similar to thematic analysis in the way that it is an inductive approach that can be used to investigate an individual's experiences, I felt thematic analysis was better suited to answer my research questions and to identify themes of common causes, consequences, and coping strategies for burnout generalised across a group of psychologists. Whereas an interpretive phenomenological analysis approach may have been more appropriate if focusing on each participant's individual experience of burnout (Cresswell, 1999).

Finally, I decided to use a thematic analysis approach as this best fit my research question and was most practically sound given the time frames of our participants. Thematic semi-structured interviews allowed participants to tell their stories and share their experiences, which many found therapeutic in a cathartic way. Although general themes were formed from the data, they were presented in a way that highlighted the detail in responses through participant's quotes; a benefit of this is that others reading this may be able to relate to specific experiences (Clarke & Braun, 2013). As my research question was broad and covered three points of enquiry, thematic analysis allowed me to capture themes from a broad range of data, while presenting them in a succinct way that may be helpful for other professionals and organisations.

Recruitment

Across eight weeks, participants were recruited via emails (see Appendix A) with a recruitment poster attached informing them about the study (see Appendix B) to several public health organisations that employ psychologists. Of these public organisations I had prior contact with some and had spoken to them about my project in an attempt to build rapport and increase the likelihood of gaining participants. Most of the organisations were based in the Waikato but recruitment emails were extended to those outside the Waikato to

gather more participants. The emails included an introduction of myself, a brief overview of the study, a poster with inclusive criteria, and an information sheet with more in-depth information about the study (see Appendix C). If a participant expressed their interest I would offer to call them to explain the process, however, most participants opted for email contact. I then emailed participants an interview guide (see Appendix D) with an outline of the interview questions and a consent form (see Appendix E). I allowed them to review this and present any questions or concerns they had. If they consented to proceed, they were then offered a choice of an in-person or online interview.

All participants opted for an online interview. This was likely due to their busy schedules and remote workplaces around the country. Although face-to-face meetings are preferable for rapport building and information sharing, online interviews have some advantages including allowing the participant to be more comfortable in their own environment, ease of rescheduling if needed without relying on a booked room/venue, and decreased travel time optimising interview time (Clarke & Braun, 2013). Since some participants were already burnt out and many disclosed they had very high workloads, online meetings allowed us to gather data in a format that did not put extra strain on our participants.

No participants opted for a support person to be present during the interview which they stated on the consent form. Some participants asked questions about anonymity and I explained that I would be allocating pseudonyms and presenting demographic information broadly.

Participants

Criteria for participation included: (1) being a registered psychologist who had (2) been practicing for two or more years, and (3) worked for a public health organisation. I decided to recruit psychologists working in the public health sector specifically, since some

research has shown that those in the public sector are more vulnerable to burnout due to the high work demands and lack of resources (Every-Palmer et al., 2024; Fischer et al., 2007; Kumar et al., 2011). I felt it was important to hear from psychologists who work within the public sector, with a goal to highlight some potential areas within the sector that require attention and awareness. I chose to recruit practising psychologists who had worked for at least two years in order to increase the validity of our sample since those who have been practising for longer are more likely to have experienced symptoms of burnout (Stone et al., 2021).

Prior to recruiting, I planned to only include full-time workers, however, I decided to extend this to part-time workers since some psychologists who had experienced burnout were working part-time as a way to prevent future burnout, and I felt it was important to include these individuals.

I recruited and interviewed 15 participants and included 14[1] in the analysis and final write-up, this allowed us to gain more perspectives of participants whilst maintaining high information power of our sample (Vanheule & Verhaeghe, 2005).

All participants have been given a pseudonym to protect participant anonymity and maintain confidentiality. Several participants raised concerns about anonymity given the nature of the topics discussed; therefore, demographic information will be presented broadly to protect participant identifiability. All participants were either registered clinical psychologists (71.5%) or registered forensic psychologists (28.5%), working in the public sector on either a part-time or full-time basis. Participants' ages ranged from 20 to 50 years,

[1] Unfortunately, one participant passed away in the course of this research. Out of respect, we have excluded their data from the study.

the time they had been working in their current role ranged from 1 to 26 years, and their experience as registered practising psychologists ranged from 2 to 31 years. All participants lived and practised in New Zealand at the time of the interviews. Participants belonged to a range of ethnicities including New Zealand/Pakeha (35.7%), NZ Māori (21.4%), European (28.6%), and American (14.3%). The sample was predominantly female with 12 identifying as women and two identifying as male.

Procedure

Interviews took approximately 50 minutes to complete and ranged from 30 to 90 minutes in a semi-structured format, therefore, some questions differed from those in the interview guide depending on the participant. At the start of the interviews, participants were provided with opportunities to ask any questions and begin the session in a way that suited them (e.g., Karakia). The process of encounter and rapport building was led by each participant as I was mindful that many participants were under high workload pressures and time constraints. Most participants were excited that I was researching burnout and felt it was a topic that needed more recognition, especially among psychologists.

At the beginning of the interview, I gave participants a brief definition of burnout from an article by Maslach and Leiter (2016), the purpose of this was to establish a foundation of understanding between myself and the participants around what burnout is. I used a mixture of open and closed-ended questions to guide the interview process. Some participants required more prompting around expanding on their answers, some provided a lot of information, and others kept their responses brief. I found that open-ended questions allowed participants to share specific memories that came up for them whereas closed

questions elicited brief responses, which were at times necessary when participants did not provide much detail.

The interview questions were categorised into three sections which will be outlined below.

- Section 1: Experiences and causes of burnout; Participants were asked to refer to any time in their career that they had experienced burnout and describe what this was like for them, I also discussed what they believe contributed to this burnout. My goal during this section of the interview was to gain descriptive information from participants about how burnout felt, to do so I asked mostly open-ended questions and at times encouraged them to describe specific memories or feelings.
- Section 2: Personal and professional implications of their burnout; participants were asked about how burnout impacted people's lives at work and at home. The purpose of this section was to gain an understanding of the extent to which burnout obstructed participant's functioning in all parts of their life and what this was like for them.
- Section 3: Management and prevention; This involved asking participants about strategies they used that helped them overcome their burnout and what they put in place in an attempt to prevent reoccurrence. It became evident that some participants were currently experiencing burnout; therefore, they spoke about how they were currently managing it and planned steps for the future.

At the end of the interview, I asked participants if there was anything they wanted to add about their experience of burnout that was not already covered during the interview, and some expressed their final thoughts. During the early stages of interviews, I asked participants for feedback on the questions, many did not provide feedback, however, some

commented on the repetitiveness of the questions and the lack of questions focusing on how personal life impacts burnout; I adjusted my questions accordingly. At the end of the interview, some participants asked more about why I had chosen to research burnout among psychologists, many were very happy to take part because they were passionate about sharing their story of burnout and raising awareness of it across the public health sector. Some participants shared that talking about burnout was therapeutic for them as they had not been allowed to share their experiences before. I thanked them for their time and informed them I would be sending out their transcripts to review and a supermarket voucher as a koha for their time. I also explained that the results of the study would be shared with them upon completion.

Interviews were transcribed using the software Otter.Ai (Otter.ai, 2023). I then listened to all of the interviews and edited the transcriptions so they reflected accurate punctuation and wording. I aimed to transcribe all interviews as 'verbatim' which is word for word including 'ums and ahhs', however, for some transcripts using verbatim reflected lots of broken sentences which distracted the reader and obstructed the point they were trying to get across. Therefore, in some instances I made slight adjustments to sentences for clarity purposes which was necessary for providing an accurate and truthful reflection of participant's experiences. (Braun and Clarke, 2006). All transcripts were emailed to participants and they were given the opportunity to change any of the wording or information in them, therefore if one believed my own editing altered their true perspective they could change this themselves. Most participants were satisfied with the accuracy and context of their transcript, some made minor grammatical changes, and some asked for certain identifying information to be taken out. If I did not receive confirmation that participants were happy with their transcript I emailed and/or called to follow up, and I gained confirmation from all 14 participants that they were satisfied with their transcript.

Ethics

The University of Waikato Human Research Ethics Committee approved this research to proceed on the 20th of May 2023 (see Appendix F). Primary issues that were considered included participant confidentiality, an emotionally sensitive topic, and cultural safety. Each of these will be discussed as follows:

Confidentiality

Given that the psychologist community in the Waikato region is small, protecting the participants' identity was important, especially due to the nature of the interviews. For example, some participants identified issues within their workplaces and industries that were contributing to burnout, and it is recognised that sharing this information may jeopardise their job position and compound their hardship (DiCicco-Bloom & Crabtree, 2006; Gubrium & Holstein, 2001). Some participants also shared personal stories of vulnerable times, therefore, maintaining anonymity was at the forefront of my mind during the writing stages of this thesis. To protect anonymity, I used pseudonyms throughout the write-up and did not include any identifying information. Additionally, no third parties were included during data transcription and was only viewed by myself and my supervisor.

All data was stored securely on my password protected laptop, and all transcripts and consent forms were distributed electronically and stored on university servers. All data will be destroyed safely five years after the data is collected.

Risk of Distress

Another ethical consideration I had was that some participants may be experiencing burnout currently and that the interview might trigger traumatic memories or emotions causing distress (DiCicco-Bloom & Crabtree, 2006). To mitigate this, I checked in with participants who expressed current symptoms of burnout around how they felt, whether they

wanted to continue or take a break, and enquired about their options for seeking support if they needed. I also made sure to discuss protective factors at the end of the interview to finish on a positive note. At the start of the interviews, I reminded participants that we may discuss content that could be triggering and encouraged them to only share information to the extent they were comfortable with. The purpose of this was to create a safe space during the interviews where information sharing was driven by the participant. Three participants disclosed they were currently burnt out during the interview, we then discussed whether they were comfortable with continuing they agreed. These three participants had plans to manage their burnout, had adequate support around them, and felt that they were able to take the necessary steps to improve it; no participants required additional resources for their burnout.

Informed Consent

Maintaining ongoing informed consent was also another ethical issue considered. To manage this, I gained both written and verbal consent throughout multiple stages of the data collection phase (Gubrium & Holstein, 2001). Informed consent is when a participant understands all relevant information about a study before deciding to participate, this includes potential benefits, consequences, and risks. Consent can be withdrawn at any stage during the data collection phase (Crow et al., 2006). All participants were over the age of 18 and because our sample consisted of registered psychologists they demonstrated experience and knowledge around informed consent as this is part of their professional core competencies in everyday practice.

All participants received an information sheet before the interview and a consent form which they signed. Consent was verbally reaffirmed at the beginning of the interview where participants were asked if they had any questions about the information sheet, consent form, or the overall study. I outlined that some topics discussed may be sensitive to some and could

elicit negative feelings and all participants gave their verbal consent to continue with the process. When sending participants their transcript they were encouraged to make any changes, and all participants returned the transcript consenting to the use of their material.

Cultural Practice

The participants were revealed to come from a variety of cultural backgrounds. A hui process was utilised during the interview phase including Mihimihi, Whakawhanauntanga, Kaupapa, and Poroporoaki (Lacey et al., 2011). I chose to use this process to develop trusting relationships with participants and create a safe space that facilitates knowledge sharing. *Mihimihi* (greetings and engagement) were shared before providing all relevant information about the study to the participants and answering any questions or concerns they may have before gaining their consent. Secondly, I utilised *Whakawhanaugatanga* (making a connection) to build rapport with the participants by asking them how they are and allowing them to lead this process of information sharing. Some participants engaged in conversation about themselves and asked me about my interest in burnout, others preferred to begin the interview immediately due to time constraints; as this process was person-centered I respected their decisions. The third aspect of the hui process is *Kaupapa* (attending to the main purpose of the encounter) which involved asking participants a range of open and closed questions about their experience with burnout. Our korero was participant-led and each individual had the freedom to talk about topics in as much or as little detail as they chose. Finally, I ended with *poroporoaki* (concluding the encounter) where I invited them to add anything they felt was not covered in the questions about their experiences. At the end of the korero, I thanked them for their time and gave an estimated time frame of when I would send their transcript to them for review. Poroporoaki can typically involve kai, however, given the nature of meeting over Zoom and time constraints this was not carried out.

Thematic Analysis

I analysed the data using reflexive thematic analysis by Clarke and Braun (2013) which involves data familiarisation, data transcribing, data coding, generating themes, refining and defining themes, and writing.

To familiarise myself with the data I listened to the audio recordings of the interviews and began to formulate potential patterns of ideas that were frequently coming up. Clarke and Braun (2013) recommend immersing yourself in the data actively therefore, when listening to the audios I thought about the meaning behind these experiences, how this may have felt for the psychologist, and how their stories may impact other areas of their life/profession. I used the software Otter.ai (Otter.ai, 2023) for transcribing and then listened to all interviews alongside the transcript to make appropriate edits.

During the coding phase of the analysis, I used the complete coding method which involves identifying 'everything and anything' in the transcripts relating to my research question. Since my research question is quite broad, I found myself with a huge number of codes making this a long process. I used a mixture of both latent and semantic codes where I saw appropriate. For latent codes, I interpreted the implicit meaning behind the quotes and for semantic codes, I used the participants' verbatim words without my own interpretation (Clarke & Braun, 2013). Once I had produced all of my codes I colour-coded them for each participant, printed, and cut these out. I then grouped them manually into three sections of my research question: causes/experiences, implications, and protective methods. I chose to do this manually rather than using software because I felt seeing the codes laid out would allow me to feel more connected and immersed in the data (Clarke & Braun, 2013). I then took each group and ordered them into smaller groups to form broader codes, while discarding any doubled-up pieces of data from the same participant. I took note of the larger groups with

codes that were supported by the majority of participants and then arranged these into potential themes. While it is important to note the patterns in the data that occur most frequently across different participants, frequency should not be the only determinant for theme inclusion, instead, it is important to highlight ideas that are meaningful to my research question (Clarke & Braun, 2013). There was a large amount of data and many ideas came up across several participants; however, I was not able to include them all and had to decide which ideas were most conducive to telling a meaningful story in my overall write-up. Excluding ideas was challenging during this stage, however, I reminded myself that qualitative analysis "is not to represent everything that was said in the data" (Clarke & Braun., 2013, p. 230).

I then refined my themes by ensuring they captured something meaningful to my research question, were unique enough to stand on their own, represented patterns in the data, and had a central organising idea (Clarke & Braun, 2013). This was not a linear process as I reviewed the codes and themes back and forth over many weeks before I decided I was happy with the themes I created. I then defined my themes by deciding on the parameters of each theme and writing a short blurb that reflected the theme's essence. Lastly, I went through the transcripts and took out quotes that I believed helped explain the essence of a particular theme and used them in the write-up.

Reflexivity

Reflexivity is the process of critically reflecting on my own role as the researcher and acknowledging I bring a particular collection of life experiences, values, views, and assumptions to the research, that can change how the research is produced. Burnout is a topic I am passionate about because I have experienced aspects of it while working in the public sector, and I was surprised at how both my work and personal life were impacted. Burnout

had not been something I had learnt about before beginning full-time work in the public health sector nor was it ever discussed during my job. After learning more about burnout and the implications it has for people this made me interested in investigating it further.

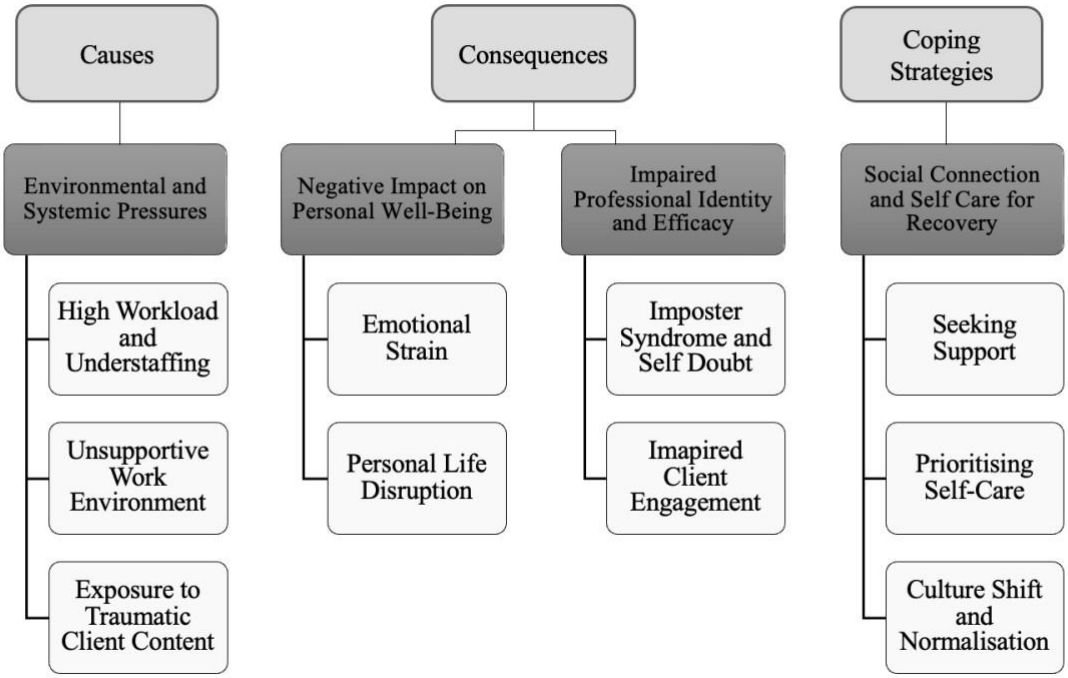
I acknowledge that my own experience of burnout symptoms may have influenced the analysis process, as data points that resonate with me are more likely to grab my attention which can impact coding and theme development. However, I interpreted the data to the best of my abilities and tried to highlight what I believed to be meaningful issues that participants presented. Qualitative research does not aim for replicability therefore, I acknowledge that if another researcher with different life experiences were to analyse the same data they may reveal different results (Clarke & Braun, 2013).

Results

This chapter will present three overarching themes that were derived from the data through a thematic analysis, these themes describe consistent shared experiences and ideas participants expressed throughout their interviews. During the data collection phase, participants were asked about causes, consequences, and coping strategies for burnout; from these three points of enquiry, four overarching themes have been derived, each consisting of several subthemes. The overarching themes include: “Environmental and systemic pressures, “Negative impact on personal well-being”, “Impaired professional identity and efficacy”, and “Social connection and self-care for recovery”. Each overarching theme consists of two or three subthemes as shown in figure 1.

Figure 1.

Overarching themes and subthemes of interviews



Environmental and Systemic Pressures

This theme encompasses the many challenges that participants face working as psychologists in the public sector, and how these factors contributed to their burnout. The subthemes I have derived from this theme include high workload and understaffing, unsupportive work environment, and exposure to traumatic client content. Supporting quotes are provided to illustrate the depth and breadth of these themes followed by the source in parentheses.

High Workload and Understaffing

Participants explained how the pressures of high workloads combined with limited staff able to meet the demands was a major issue within the public health sector and strongly contributed to their burnout. Participants explained that the workload expectations in their role were extremely high due to the demand for people needing help being larger than available psychologists:

> We just need more and more psychologists, more nurses, more occupational therapists. I think probably in the whole health sector, the workload is way, way too much. (Niko)

> Resourcing is the biggest thing so when there's less staff its more stressful. (Kiri)

> It's mostly about resources. So it's mostly about the fact that there are just not enough staff and so everyone in the team is impacted by that. That there is just so much demand that comes in, but there's not enough people to meet the demand. (Liam)

> I think, if in our department, if people didn't have such high workloads, then they wouldn't be so stressed. But I know that the nature of the job that we're in, it's continuous. (Zoe)

This high demand of people needing support and the limited resources available for these people result in high patient waitlists creating more pressure placed on psychologists to see as many patients as they can. Participants spoke about the responsibility put on them as practitioners to 'make it work' and find solutions to the organisations' resourcing problems:

> There is a lot of demands in terms of picking up more clients because we have long waitlists. So this pressure to work faster, more efficiently, pick up more clients, close more cases, and have more client hours. (Grace)

> So the impact on me has been like to figure out solutions as to how we can maintain targets and contracts with like less people to do it. And I'm just like, I can't, I can't do it anymore. I'm too tired. (Hana)

Participants spoke about how the pressure of high waitlists and workload meant that they prioritised their work over their personal life which made it difficult to maintain a work/life balance. Participants spoke about putting client and organisational needs before themselves, overcommitting to work tasks, and allowing their own high personal standards to justify doing work beyond their capacity:

> It's that creep, and then you just like end up working longer hours because that's what you're used to doing, and then you start taking on more responsibility, and that keeps it, and so a lot of it was my own lack of kind of working boundaries. (Quin)

> I've always prided myself in working hard and getting stuff done and doing the best I can, but sometimes often to my own detriment, because I'll put everybody else first before myself, so then I get burnt out. (Hana)

Participants spoke about systemic changes that should be implemented to help increase the workforce of mental health practitioners and keep clinicians in the job.

Participants proposed that increased pay, flexible working arrangements, and more leave would help staff retention.

Many discussed the temptation to move to private practice due to higher earning potential and more flexibility around the type and number of clients you can accept. Flexibility within the role was a strong motivator for staying in a job:

> There's a lot of flexibility and I think that's part of the reason I've stayed there so long, so within my job I've been able to be really autonomous in what I do and how I structure my time, and I think that's been really important. (Julie)

> The general feedback from a lot of my psychologist, colleagues and friends is, you don't get paid enough given the level of work that's expected. And so people go into private practice for that reason. (Hana)

Others spoke about the need for flexible sick leave or ‘mental health days’ to take when you’re feeling run down mentally.

> How sick leave is used? Like people assume it's for like, physical illness. Whereas, yeah, it should be used quite flexibly for whatever the person needs. (Mia)

Participants spoke about the importance of having sufficient annual leave and taking a break, however, acknowledged that with the nature of the job, the workload remains when you return to work, which can interfere with your ability to take a proper break:

> I'm always working on the weekends trying to like do stuff so that I'm not behind during the week … But my thought is that if I can continue working, then I won't get burnt out. Because then the thing that I feel stressed out by the most is like when I'm behind … no one does my work, no one picks it up. So it's just waiting for me. (Hana)

Quin spoke about the pros and cons of having a four-day work week:

> I would be happy to do say four days at 10 hours to get a 40 hour workweek … But you sort of wonder, then is the same amount of work just squished into the small amount of time? In which case actually it's almost worse … I don't know if that would add more stress or less stress. (Quin)

Participants also proposed that improving organisational systems would help with staff retention. Participants spoke about how more efficient systems within the workplace could help reduce workload giving them time for client contact and preparation. Some raised issues about the heavy admin demands on psychologists which were time consuming and not the best use of their clinical skill set:

> If we could have competent administrative support, a lot of the time spent at work is doing administrative things that are not the best use of my skill set or my training. (Eden)

> Less admin stuff so kind of changing processes so that we don't spend that much time on admin stuff … They just need to optimise their system, their referral system, so many things need to change in this system to make it make it less stressful for everyone and make reports less freaking long. (Grace)

Many participants spoke about how it is common for psychologists to have perfectionistic personality traits, which make them more vulnerable to over-working and burning out. Many psychologists get into the work because of their empathetic nature, which can make them more vulnerable to secondary traumatic stress or compassion fatigue. Participants spoke about the high expectations they often hold for themselves and their tolerance for high pressure work environments:

> I think the type of people that tend to go into psychology tend to be perfectionists, and I think we have very high expectations of ourselves … we inherently push ourselves to be as good as we can and work hard and you don't notice burnout until you're burnt out sometimes. (Quin)

Participants recognise that their perfectionist personality traits persist across workplaces and they acknowledge needing to actively put effort into self-care:

> And I've always been quite a perfectionist, which probably is why my pattern of selfcare has never really been great across jobs. (Hana)

Participants also spoke about how their empathy for others can drive them to overcommit which can lead to burnout. Participants mentioned how the level of passion and commitment they give to their clients can cause them to feel personally responsible for their improvement which acts as a burden:

> We're trying to find new solutions, when in fact, I think probably what we need to do is just relax and realise the fact that therapy is really slow with this person because the person's got significant mental health or personality difficulties … I think sometimes if we don't see it happening as quickly as we want to … but I think we often forget about that, and we internalise it and think it's something to do with us that we need to work harder, or we need to work longer. (Julie)

> Because usually quite empathic people go into psychology, and it's very difficult to I suppose shake other people's problems off you at the end of the day, kind of take the work coat off, you kind of carry it with you without even realising. (Grace)

Unsupportive Work Environment

Many participants reported that system issues within the workplace contributed to their burnout, including an unsupportive work environment and not feeling appreciated or listened to by their superiors.

Participants spoke about their experiences of speaking to their managers about their burnout, this was a mixed response with some managers being supportive and others being less supportive. However, the level of support and understanding from managers played a critical role in improving or worsening the participant's burnout. Participants spoke of how managers can be too focused on outcomes with little appreciation for the work that is being done:

> I work weekends, and I'm still being told that I haven't done enough, and the not enough that I'm doing is like organisational stuff not like related to my clients or my work, which doesn't even get asked about actually. (Hana)

Paige spoke about how some work environments have a clear hierarchy of roles and this imbalance of power between managers and employees can cause disconnect, contributing to burnout:

> I think that all that kind of stuff can be much more improved which I think would involve better communication between people at the top of the chain and people at the bottom of the chain, like less of a hierarchical kind of system would be helpful … Where feedback is not really listened to and it's really hard to make changes. (Paige)

Others mentioned how having a supportive manager was helpful in improving their burnout:

> The most important was that she was really understanding and supportive and that she gave me the time to work it out, I think that was the most important thing to me, so she wasn't she wasn't in a rush to get me back to work. (Niko)

Many participants talked about raising issues in their workplace but not feeling listened to or valued as an employee, this left some participants feeling hopeless that any positive change would occur:

> I kind of gave a lot of feedback about some changes that could happen in that space, but they didn't really eventuate. So and I think that really contributed to that those cynical kind of disillusioned feelings. (Bella)

> Raising issues and being told “yeah, we'll get on to it” or “yeah, something will happen”. And it not. Yeah, I think that was a real flaw in the system that I think was a major player as well … It's think after a while, I started thinking, what's the point? I've raised this? it's falling on deaf ears and you're not doing anything about it. (Ivy)

Eden spoke about feeling as though she was being used for her license in a workplace that would not listen to any issues she was raising.

> I was asking some questions, and they weren't being addressed, like they weren't answering the questions and so I was getting pissed … And so not feeling heard and feeling dismissed when I was asking very pragmatic questions in a very professional manner and so that was when I was really like, “I'm just a tool, I'm just an instrument, I'm being used for my licence. (Eden)

Exposure to Traumatic Client Content

Many participants acknowledged feeling the strain on their mental health after being repetitively exposed to traumatic content through their client work, even if this was occurring

implicitly. Most participants reported that secondary traumatic stress (STS) was not a cause of burnout, but instead a consequence of working with complex clients, and many reported using effective strategies to manage this ongoing exposure to trauma.

Participants shared difficulty compartmentalising from client content, and how emotionally taxing it can be working with chronically unwell people who have faced significant trauma and adversity throughout their lives. Kiri described her experience with ongoing exposure to traumatic content, she reported feeling:

> Detachment and almost like a trauma response to some of the content that I am exposed to … Not being able to turn my computer on to read through that material. (Kiri)

> There was definitely I guess vicarious trauma if you like to call it that or trauma from my clients at that time that was impacting on me and it was really difficult to compartmentalise. (Julie)

> From the nature of the work, it's an emotional roller coaster we take on other people's mental health issues. And I think I think a lot of people take stuff home. (Zoe)

Liam spoke about struggling to see clients in distress but having limited ability to help:

> It's the heaviness that comes with empathizing with someone's suffering and the unfairness of what has happened in their life, but having relatively limited ability to be able to create relief from the suffering that that they're undergoing … and not being able to do very much as a single clinician seeing someone one hour a week. (Liam)

Participants described incidences of how exposure to traumatic content and offending histories from clients manifested in their personal lives by changing the way they saw the world and their perception of safety:

> I began to get a little bit paranoid about people when I left work, in the evening, I was scared to go down to the car park to get my car, just things that I'd never been afraid of before I suddenly felt afraid of … The way that it manifested though was in terms of like a fear of … not a fear of clients, but a general fear, I suppose, of just bad things happening to me. (Hana)

Participants shared their experiences of how hearing traumatic client content caused them to be more cynical in their personal lives. Others spoke about how it can be lonely holding this information and not being able to offload at the end of the day with your partner or support systems due to confidentiality and the disturbing nature of the material:

> It's that secondary trauma and response I think is that you know, your job is to help people sort out really difficult problems and some of those problems are complex things that have happened out there in society are distressing. And you know, in your own life, you don't encounter that kind of stuff well, certainly I don't all the time. And so you are hearing so much that you can become cynical about the world. (Kiri)

On the other hand, some participants felt they were not impacted by their client's content and were able to emotionally compartmentalise from this after years of practice:

> I'm quite good at keeping a sort of emotional distance that yes, I'm still empathic, I still can be there for my clients as psychologists, but usually I'm not too affected on a personal level. (Niko)

> Trauma is something that I'm very comfortable with maintaining professional boundaries around and taking care of myself when exposed to really horrific content. (Eden)

Paige shares how ongoing exposure has made her desensitised to the client's trauma:

> I felt like I know intellectually that there will be an impact on me. But I think I'm so used to it now that I've reached a point that it doesn't, to be honest. So I think the stuff I get from my clients no longer has a direct obvious impact on me. (Paige)

Negative Impact on Personal Well-being

Theme two describes the negative impact burnout had on the personal lives of participants. All participants to some extent described burnout as a painful, draining, and consuming experience that was accompanied by many negative emotions and feelings that seeped into their personal lives. The subthemes I have derived from this theme are emotional strain and personal life disruption.

Emotional Strain

All participants shared negative experiences and emotions associated with burnout, many felt burnout was overwhelming, exhausting and consuming. All participants experienced some form of anxiety and depressive symptoms, and/or heightened emotionality:

> Horrible is a good word, so horrible, I wasn't productive in what I was doing. I spent a lot avoiding. I spent a lot of time crying. Yeah, it was horrible. (Zoe)

> I was crying before work. And that real, feeling sick everyday driving in, and then I was like, this isn't normal. This should not be like this. (Ivy)

> When I'm burned out, I feel moderately clinically depressed. (Liam)

Some described burnout as a ‘slow creep’ where they didn’t recognise they were experiencing burnout until they were in the thick of it, many participants spoke about not having much knowledge of burnout before experiencing it highlighting a need for increased awareness around burnout:

> I think it's such an insidious slow thing to occur I didn't recognise that was occurring at the time … I don't think I really knew anything about burnout. (Julie)

> It caught me by surprise … I wouldn't have expected this to happen to me. (Niko)

A lot of participants expressed feelings of **shame and guilt** which accompanied burnout, many hid their burnout from others trying to push through it on their own.

> I think there's quite a lot of shame around people admitting that they've felt burnt out … I think people see it as a personal failure that they've burned out when no one else in the office has … so people don't talk about it and I think fundamentally, if we can raise awareness about it and have information that people can use to recover from burnout and then prevent burnout later, would be fantastic. (Julie)

> I think another issue that contributed, that was a personal thing for me that work ethic and thinking, be a people pleaser, be thankful, I think, for my generation, be thankful you got a job at one job for life, hang in there. (Ivy)

Participants spoke about how their personality traits of being perfectionists and people pleasers can make admitting they need help a very vulnerable and scary act:

> I felt like a different person, I felt more vulnerable, guilty about a lot of things, and also the feeling of letting people down. (Niko)

Participants spoke about how the shame and stigma around burnout acted as a barrier to seeking help:

> I should be able to sort things for myself … That a kind of a false belief that probably many clinicians fall into, that if you can't sort out your own problems, you can't sort out anyone else's, so you should sort out your own. (Liam)

> I think it's because you just kind of think that you should just get on with it. And I guess, probably the stigma associated with it. (Amber)

Personal life Disruption

Many participants spoke about how their burnout presented in their personal lives by being too exhausted to achieve basic day-to-day tasks. Engaging in self-care tasks, hobbies and social connection were examples that took a back seat for participants suffering from burnout.

Emotional and physical exhaustion was a common experience for participants, which interfered with their functioning across personal and professional aspects of their lives:

> Fatigue in all areas of my life. So I suppose if we think about even Te Whare Tapa Wha just like physically, emotionally, in terms of work life balance, impact on my family, my relationships, spiritually, I think it's quite a holistic exhaustion. (Hana)

> I feel so exhausted by the work that I don't have any energy for my hobbies barely have energy to do what I need to do. (Grace)

Many participants found socialising very mentally taxing when they were burnt out and reported being too exhausted to see their friends or whanau which led them to becoming more isolated and alone:

> At home, I was quite a lot more irritable and I also didn't really feel like I wanted to go anywhere … It was kind of disappointing because I did have a whole month off but didn't really get to see friends because I didn't really have the energy or didn't really feel like I wanted to go and do a lot. (Julie)

> I just think that kind of lack of motivation influences everything. And I can't be bothered catching up with people doing the things that you might normally enjoy that kind of thing. (Amber)

Some participants spoke about how their burnout impacted their personal life and meant they weren't as present at home with their spouse and/or family. While others reported their burnout didn't impact their personal relationships:

> I think it had the most impact at home, like I said I was really grumpy, not the best parent and husband probably, I think they took the hardest hit. (Niko)

Impaired Professional Identity and Efficacy

This theme highlights the consequences of burnout on participant's professional lives. Many participants experienced strong feelings of self-doubt and symptoms of imposter syndrome that led them to question their professional identity. For some burnout impacted the way participants were able to engage and connect with their clients, however, many described their client work as their 'saving grace' while channelling all of their energy into this.

Imposter Syndrome and Self-Doubt

Most participants expressed how they experienced imposter syndrome during burnout which caused them to doubt their professional ability. Participants reported questioning their clinical judgement for the first time in their career, taking a lot longer to make decisions,

comparing themselves negatively to other clinicians, feeling a sense of hopelessness, and considering whether they were a bad psychologist:

> I guess everything feels hard in therapy, it feels like the clients are hard, the problems are hard, their goals are hard to achieve. I feel like I don't have the skills or the capability and I would be thinking that other colleagues would probably do much better with this client if they were seeing them right now. (Liam)

> I just felt like I was a complete failure as a psychologist … It just felt like I couldn't get anything right. No matter what I did, it was always the wrong thing. So I just kind of felt hopeless. (Zoe)

> I think maybe when things weren't going very well with a client, as in they weren't progressing in the way that I would like, I probably blamed myself a bit more for it. (Amber)

One participant reported that their clinical reasoning was so impacted by this selfdoubt they feared they were at risk of unsafe practice and knew then that it was time to take a break:

> I was really fearful I'm going to make a decision that's going to be damaging to me, or the organisation, or client or all three. And then I recognise you got to stop. When you're at that point where I didn't trust my judgement. Ethically, I'm unsafe now. (Ivy)

Some participants reported that being a psychologist was part of their **identity** and that this self-doubt made them question 'Who are they if not a psychologist?' All participants reported considering changing careers or roles due to their burnout, which was a huge decision to grapple with after spending so much time and energy building their professional careers:

> I guess my sense of identity is quite strongly linked to my professional identity. (Bella)

> It made me feel unsatisfied with my life, I suppose with my life choices, I started questioning my life choices, and the choice of profession. (Grace)

> I would call it kind of like an existential crisis of like, is this what life's about? And what would I be like if I wasn't identified as a hard working psychologist or someone who's like gives it their all? Who would I be? (Quin)

> And tried to separate out or focus on other parts of my identity that weren't focused on being a psychologist, because it totally had me that was my identity … there was lots of fear for me. If I was choosing to not practice ever again, then who am I and what would I do? And then it took a long time to grapple with that and find some peace with that. (Ivy)

Impaired Client Engagement

Participants spoke about how burnout impacted their ability to engage with their clients in the way that they would like. Some spoke about not having the time or energy to do the prep work for clients:

> When I come out of a session feeling like I'm not making as much progress with this client as I should be. I know it's due to like lack of prep … I haven't had time to like look into resources that I can offer this mum who's struggling with her parenting, things that normally I'd have lots of time to prep for or having consults with my colleagues around how I can work with a particular client - all of that stuff becomes a bit of a luxury. (Hana)

Participants spoke about the ethical dilemma of wanting to provide thorough care to clients but simultaneously having to meet targets, as a result of this pressure many spoke about not being able to practice in the way they saw ethically appropriate. Wanting to help but working within a system that could not provide adequate resources to do so weighed heavily on participants:

> I do think that that's probably been the harshest type of burnout for me is to sit as a psychologist who has ethical and clinical responsibilities to my clients, and trying to balance that with the organisational needs in terms of what the agency needs and expects me to do. (Hana)

One participant spoke about how a combination of the high workload and burnout caused them to have to change their approach to less person-centred, and more 'cookie cutter' to keep up with the expectations of their workplace:

> I needed to change my approach and be really kind of heartless, and just treat it like a job - which it is, but really do much more disconnected, just skills based CBT like not really getting to know people and just treating their referral diagnoses and not getting a context for their life, so the quality of my work would need to diminish and it would be a much more like rubber stamp, sort of cookie cutter approach. (Eden)

Others reported experiences of depersonalisation and compassion fatigue that may have impacted their presence with their clients:

> I feel like I'm not providing as much value in terms of the work, I don't have as much creativity, I don't have as much energy, interest, and just hopefulness for people. (Liam)

> I think the most important thing was that I really … that I sort of lost my compassion for my work, for my clients, sometimes I'd be going to see clients and thinking ahh I don't want to. (Niko)

> Yeah, it's kind of like their issues felt quite small in comparison to what I thought I had going on. Like, it's maybe harder to put those things into perspective in the way that I normally would. (Mia)

Although many participants admitted their burnout may have impacted their presence with clients, most reported that seeing their clients was their 'saving grace' and that they put all of their energy and effort into their sessions causing other areas to suffer such as admin work. Participants were passionate and enthusiastic about their client work and experiencing burnout was devastating for many because it impacted their ability to do the job they love:

> But mostly for me the burnout was related more to system/systemic issues rather than clients. So I wouldn't say that the people I've worked with have been ever solely responsible for me feeling burnout, it's been a symptom of the system that I work in and if anything, the clients have been the best part of the work. (Paige)

> So in terms of quality of care, you know, that you prioritise the care of the client ... That's where you put all your energy is into your clients, so it's kind of more in other things that it impacts like, you know, your admin or relationships with colleagues, your ability to do extra tasks, but your clients I would hope, I mean, that you're putting you put your whole self there. And that's, I think, why you're getting burnt out because you're putting so much into that. (Kiri)

> Because that was kind of the saving grace for being able to see clients. So I was quite enthusiastic about that. And still being able to do that. Yeah, I just didn't do as much because of the other stuff. (Bella)

Social Connection and Self-Care for Recovery

Theme three covers the importance of social connection and self-care for recovery. As all participants agreed burnout is an extremely negative process, everyone could identify protective strategies they used to improve their burnout. Social connection was a strong theme across participants; all participants reported sharing their experience of burnout with others helped alleviate the burden and validate their feelings, and participants felt a more supportive and collegial workplace would help prevent burnout among staff. Self-care was also identified as an important protective factor including maintaining strong work-life boundaries, prioritising physical and mental health, and making time for enjoyable activities outside of work. Many discussed a need for a shift in culture around the way we view burnout as a personal problem, and how normalising it will encourage those struggling to ask for help.

Seeking Support

Many participants identified how important it is to seek support from your managers or supervisors when experiencing burnout. Some participants felt dread about approaching their managers about their burnout, while others who received a supportive response from managers found this integral in their recovery:

> So just having good supervision and having supervisors who can tolerate you talking about things that might make them feel more anxious, I think, again, some people, you might use the word burnout and people panic and then they become very reactive rather than supportive so I think having supervisors that just sit with you and allow

> you to talk about how you're feeling, not jump to any conclusions, not pull you out of work or whatever you're doing, and so someone that's just willing to listen. (Paige)

Some participants reported that having an external supervisor or seeking support from an external counselling agency was really helpful because it was separate from their workplace:

> I think one of the big things actually was getting an external supervisor. So it just makes it easier to talk about that kind of stuff rather than somebody that's in your workplace. (Amber)

Some participants spoke about how informal ways of sharing experiences of burnout with colleagues would be helpful instead of formal training or workshops, some mentioned that participating in this interview was helpful for them because it allowed them to reflect on their experiences for the first time:

> Being able to talk more about our experiences, I know we have trainings and we read articles and we do all of that but this has actually been really helpful so you know having those shared opportunities to talk about burnout it an informal and relaxed way, and you know you can support other staff or receive the support. (Zoe)

Participants reported seeking support from friends or loved ones helped when they were burnt out, some spoke about instances where they shared their experience of burnout with friends or past colleagues and were surprised that those individuals had struggled with burnout in the past as well which was validating.

> I talked to my colleagues/friends and I suppose when I talk to them, it still counts as like outside of work because they're also my friends and so sharing it with people who understand the situation is helpful. (Hana)

> It's not like I sought professional help but with the support of my wife, I got pretty good support for my team leader as well, had a good couple of good conversation with friends. (Niko)

> My pattern is to share with the people who I trust and love. (Eden)

Participants explained that a more collegial workplace would help to improve burnout, this includes more understanding and proactive managers, a focus on team bonding exercises, and prioritising peer support and teamwork amongst colleagues.

Many participants reported a need for a more supportive and understanding approach from managers in relation to burnout:

> I think what's really important is for team leaders and managers is to stay in touch with your team members and yeah, just ask how everyone is, so "is everyone's still coping with the workload, is there anything we can we can do?" Just to have the conversation I guess? (Niko)

> Managers I think hold a lot of power and some can use that really well and foster more of a collaborative, like equal kind of space I guess be more part of the team. (Paige)

Some participants spoke about the importance of team bonding activities in the workplace to better unite colleagues together and foster an environment where they could support each other. Participants spoke about how exercises such as BBQs, quizzes, family days, sharing meals, and social events outside of work may be helpful in building stronger relationships with colleagues, in order to feel more comfortable reaching out to them for support in future if they need.

> Just kind of downtime at work, you know, teams having lunch together, and I don't know stopping to do the Stuff quiz and those sorts of things, I think are all really important in terms of building a supportive team culture and fun team culture. (Paige)

Participants spoke about the importance of peer support in the workplace for protecting against burnout but acknowledged that due to the high workloads, there is not enough time for team building and therefore collegial relationships suffer.

> A more active approach as a team to encouraging healthy practices, but a lot of us will work through lunch, we'll eat at our desks, or we just go go go all the time. So that regular team discussions about that culture that we've got. (Ivy)

Julie reported that spending less time with their colleagues was actually a protective factor because it meant they had more time to spend at home, and how prioritising their home life comes at the expense of her relationships with her colleagues:

> I've kept the boundaries quite tight in order to get my work done without impacting on my family life but in doing that, it means that I don't socialise as much with my colleagues as what some other people do. (Julie)

Prioritising Self-care

Participants expressed the importance of self-care and preserving your well-being in order to help others effectively in practice. For some participants the importance of self-care was only discovered after their period of burnout, however, they recognise it is needed to be able to maintain the high level of work and responsibilities they have in their job. Self-care strategies participants used included maintaining clear work-life boundaries, prioritising physical and mental health, and making time for hobbies.

Participants recognised that maintaining work-life boundaries was difficult at times but crucial for preventing burnout:

> I'm much more assertive in the workplace with my manager, so if I get asked to do tasks that I know I don't have time to do I just say “no” and I say “well no I can't do that” or “I can do that but what tasks do you want me to drop?” Whereas I noticed in the past, I would just say yes to everything which then meant I had to work crazy hours to get things done and had commitments that I couldn't really fulfil. (Julie)

> I have boundaries as to when I'm at work and when I go home, like I don't generally work more than an eight hour day anymore. I have hobbies that I get involved in. (Quin)

Participants shared the importance of practising self-care and engaging in things they enjoy. This looked different for everyone and included exercising, eating good food, spending time with loved ones, watching TV, physical labour, spending time with animals, and implementing mindfulness strategies.

> Try to do exercise. Try to be more present and my interactions with my family. Ensure that I'm getting enough sleep and I'm eating well. (Amber)

> I spend a lot of time with my dogs. I spend a lot of time I switch off work when I leave work. So, I leave my work at work or at least I try my best to, I have a few TV programs that I like to watch. I do a lot of gardening. Doing a lot of maintenance on my house. So just keeping myself busy I think, oh and spending time with other people. (Zoe)

Finally, most participants recognised that self-care is difficult, however, critical for them to keep themselves well to be present for their clients.

> The pressure of your own well-being when you're busy looking after everybody else's well-being, quite similar to just being a mum you're busy looking after everybody else that you're often the last person to have any self-care. (Amber)

> I guess the key one that I'll land on is just more education and keeping those discussions going. And recognising the toll that the jobs take on us. And emphasising the importance of us in caring for ourselves first, and the ethical responsibility we've got for us to be well in order to support our clients. (Ivy)

Culture Shift and Normalisation

Many participants reported a need for a culture change where burnout is understood as a result of poor working conditions rather than a personal issue. Some participants explained how they were made to believe burnout was a personal failing that they needed to fix on their own, even though upon reflection realised it was a result of systemic issues within the workplace, in which the workplace needed to take accountability for:

> The situation is often the cause, rather than the actual individual. And I feel like there's much more of a focus on the individual experiencing the symptoms, rather than actually, what's the underlying cause? (Bella)

Participants spoke about instances where they had approached their managers with concerns about their burnout and their managers advised they improve their selfcare/organisation skills without any talk about changing internal systems:

> But I also feel like it's acknowledged that I'm not good at it (self-care). But there's no kind of management plan around how to decrease it, it's kind of left up to me, because it's like (participant) you're no good at self-care, that's something you know, you need

to work on, you should really look after yourself. But then the responsibilities don't lessen. (Hana)

Many spoke about how burnout needs to be **normalised** and not seen as something to be ashamed of or dismissed. Participants spoke about feeling alone in their burnout, not being aware of what it is, not knowing to look out for signs, not hearing people openly discuss it in the workplace environment and how this needs to change:

I don't think there's enough awareness around it. And it's kind of like we can work in environments where we're under like a paradigm of 'go until you're broken, and then stop' you know, and I think that needs to change in terms of like, actually preventing it because once you hit burnout, it's very hard to climb out of it. … We shouldn't be the ambulance at the bottom of the cliff for ourselves. (Quin)

And I suppose that's going off what's helped me as a clinician that this is normalising it, it think in your early career as a psychologist you're like burnout that's never going to happen to me what is that weird thing over there so yeah more of those discussions about it informally and normalising it and I guess being clear this is not career ending there are options and you can get through this, it won't always be this way. (Kiri)

Maybe have more discussions about it … so signs of burnout, early warning signs and that kind of thing. So that we can grow some awareness about it, because it feels like some people have been in the profession for 10 plus years have been burnt out for the longest time, but they never noticed and never did anything about it. (Grace)

Trying to normalise it a little bit more because it totally makes sense yeah that actually when you're busy trying to help other people with their wellness, that that does have an influence and maybe just a bit more awareness about it. (Amber)

Participants spoke about how increasing awareness of burnout can target the shame associated with it and therefore encourage those to reach out for support:

I think that is really important that you sort of … trying to step ahead of the of the shame and the feeling of being a failure … So I think just acknowledging like hey, I'm just a human being and it can happen to all of us, and don't feel embarrassed about it. (Niko)

Discussion

The results of this study highlighted the experiences of burnout among practising psychologists in New Zealand. Participants shared the challenges of working as a psychologist in the public mental health sector and how high workloads and under-resourcing strongly contributed to their burnout, at times further exacerbated by an unsupportive work environment. Burnout had significant negative consequences for their personal well-being as well as their professional identity and efficacy. Social connection and self-care were strong protective factors for professionals. Many identified a need for a culture shift within workplaces for them to acknowledge their role in mitigating burnout, and through increasing awareness and normalisation this could promote help-seeking in the workplace.

Environmental and Systemic Pressures

The results show that high workload and understaffing were strong themes that contributed to psychologists' burnout. With the demand for mental health support being larger than available resources, participants spoke about the immense pressure that is placed on them to manage. Many identified a strong need for more psychologists and mental health professionals in the public sector workforce. Under-resourcing in the public health sector is a significant problem documented in the literature both globally (Hammond et al., 2018; Johnson et al., 2018; McCormack et al., 2018; O'Connor et al., 2018; Vivolo et al., 2022; Yang & Hayes, 2020) and within New Zealand (Blayney & Kercher, 2023; Chambers & Frampton, 2022; Every-Palmer et al., 2024). A New Zealand study reported that 94% of psychiatrists felt the mental health sector had insufficient resourcing (Every-Palmer et al., 2024) and were frustrated that the demand for service is increasing over time without any plan to increase resources and staffing within the public sector (Chambers & Frampton, 2022). A consequence of under-resourcing in the public health sector is that it maintains long waitlists and puts vulnerable clients at risk, 98% of a sample of New Zealand clinicians

reported that often individuals who needed specialised treatment were not able to access adequate care due to insufficient resources within the workplace (Every-Palmer et al., 2024). Furthermore, by only having enough resources to treat the most severe mental health cases, this creates an 'ambulance at the bottom of the hill' system that we are seeing in New Zealand; a study found that only 31% of individuals with a year long history of suicide attempts received psychiatric treatment (Beautrais et al., 2006).

This study found that participants were vulnerable to becoming burnt out in organisations that were under-resourced because they felt obliged to work overtime, making it difficult to maintain a work/life balance. Research supports this, and shows clinicians often work overtime to keep up with admin work (Blayney & Kercher, 2023; Chambers & Frampton, 2022). This study found that participants may fall into this pattern of over working because of their high personal standards and strong empathy for others. It can be extremely difficult seeing clients struggle at the hands of systemic issues that often drive them to work beyond their capacity (Blayney & Kercher, 2023; Every-Palmer et al., 2024). Understandably, psychologists who work over-time are prone to burnout as existing research shows that maintaining work boundaries and prioritising personal lives is crucial for protecting against burnout (Blayney & Kercher, 2023; Fischer et al., 2007; Maslach, 2017; Maslach & Goldberg, 1998; Morse et al., 2012).

A potential consequence of under-resourcing within the public sector is the risk of psychologists moving into the private sector. Some participants contemplated moving into the private sector for more flexibility to practise how they saw ethically appropriate without the pressure to meet organisational demands. Research suggests private psychologists have more control over their hours, client numbers, and administrative responsibilities, leading to higher job satisfaction and personal accomplishment (Ackerley et al., 1988; Hellman & Morrison,

1987; McCormack et al., 2018; Rupert & Kent, 2007; Vredenburgh et al., 1999). With the existing number of practising psychologists in the public sector already being low, this could pose a threat to the mental health sector if psychologists move to private (Every-Palmer et al., 2024).

An unsupportive work environment was a theme that worsened burnout for participants. Despite numerous systemic issues within the public sector, participants reported instances of raising feedback to their managers that were never addressed nor resolved, after a while participants felt hopeless that any change would occur. Some participants shared how they felt undervalued in a workplace that prioritised numbers and outputs over employee collaboration and well-being; others felt they were being used for their practising license because their ideas were being dismissed by their hierarchies. Participants shared a need for managers to be more understanding of the pressures on psychologists, more sensitive to the signs of burnout, and more responsive to feedback. For participants, the level of support they received from their managers when struggling played a critical role in either improving or worsening their burnout. Research supports this and states that working in an unsupportive environment can worsen burnout for professionals when the role is already very mentally taxing, managers and supervisors can be instrumental in supporting professionals and addressing early signs of burnout (Maslach & Leiter, 2016, 2017; Vivolo et al., 2022). These findings were also consistent with the study by Blayney and Kercher (2023) where psychologists shared frustrations of having a huge amount of responsibility with no ability to make changes within the workplace, and how this contributed to their burnout.

Negative Impact on Personal Wellbeing

For most participants, burnout was a hugely negative and painful experience that had significantly impacted their personal well-being. Participants experienced a decline in their

well-being and heightened distress with feelings of emotional exhaustion, overwhelm, anxiety, depression, and tearfulness. Participants spoke about 'feeling sick' before work, crying at work, and dreading going into work. This is consistent with the literature that shows burnout is commonly accompanied by anxiety and depressive symptoms such as hopelessness, anhedonia, sleep disturbances, fatigue, negative feelings, and concentration issues (Ahola et al., 2005; Bianchi et al., 2015; Blayney & Kercher, 2023; Kumar et al., 2011). Participants found that burnout made it harder to compartmentalise from traumatic client content that they were exposed to in their work. This manifested in their personal life through intrusive imagery, altered sense of safety, increased paranoia, and cynicism towards others and the world which many found unsettling. These findings support the theory that exposure to traumatic material can lead to forms of secondary distress in clinician's personal lives, with evidence showing individuals may experience intrusive thoughts, flashbacks, and dreams, as well as disruptions to personal schemas, alienation from friends and family, and increased wariness of personal safety (Ilife & Steed, 2000; McCann & Pearlman, 1990; Steed & Downing, 1998). On the other hand, some participants felt that exposure to traumatic client content no longer affected them after years of practice and that they were able to manage this through self-care and emotional distancing. Literature debates whether secondary traumatic stress causes burnout or whether secondary traumatic stress is a result of burnout because individuals have less energy and coping mechanisms to protect themselves. Regardless, studies suggest there is a relationship between the two concepts and further research is required to understand its impact on mental health professionals (Devilly et al., 2009; SabinFarrell & Turpin, 2003).

Feelings of shame and guilt were common among participants during burnout, many felt ashamed of their burnout as though it was a personal failing. Some believed they should be able to solve their own issues before attempting to solve other people's. This shame caused

people to hide their burnout from others and attempt to push through without seeking help. Research suggests physicians are often reluctant to seek help for burnout due to feeling uncomfortable with being a patient and fear of professional and social judgment (Lenoir et al., 2021). Furthermore, studies confirm that the negative stigma associated with burnout creates barriers to help-seeking often causing individuals to suffer in silence, further worsening their mental health (Lenoir et al., 2021; Maslach & Goldberg, 1998; Vivolo et al., 2022). An explanation for this stigma around burnout is that it is viewed as a personal issue and not an organisational issue, and therefore, psychologists may feel they will be blamed for this (Maslach & Goldberg, 1998). Another possible explanation for these feelings of shame is that psychologists often possess perfectionist personality traits that involve high standards for themselves, causing them to be more likely to associate burnout with failure (Alarcon et al., 2009; Maslach et al., 2001). The findings of this study supports this as many participants spoke of having perfectionistic traits causing them to over-work until they burnt out.

Extreme emotional and physical exhaustion both at home and at work were common symptoms of burnout for participants. Many did not have the energy or motivation to complete their normal day-to-day routines at home such as self-care tasks, hobbies, and socialisation. Some felt they became isolated and lonely from not having the energy to engage with friends and family. This is consistent with the research as exhaustion is the most commonly reported and researched symptom of burnout (McCormack et al., 2018; O'Connor et al., 2018). Exhaustion can be dangerous as it can leave the body more vulnerable to physical illnesses (Honkonen et al., 2006; Maslach, 2017), and mean individuals are unable to engage in enjoyable activities such as hobbies, quality time with loved ones, and socialisation, tasks that would normally help improve emotional exhaustion and depression symptoms (Hamaideh, 2011; Li et al., 2023; Maslach, 2017; Maslach & Goldberg, 1998; Vivolo et al., 2022). Although many shared feelings of physical exhaustion, very few

participants shared other physical symptoms of burnout, this differed from the literature as studies have found burnout to be linked with many physical health problems such as cardiovascular diseases, gastrointestinal issues, headaches, respiratory issues, insomnia, muscle pain, and high cholesterol related disorders (Honkonen et al., 2006; Kakiashvili et al., 2013; Melamed et al., 2006; Salvagioni et al., 2017).

Impaired Professional Identity and Efficacy

Many participants experienced symptoms of imposter syndrome and a loss of confidence in their practice which impacted their identity as a psychologist. Participants spoke of overwhelming feelings of self-doubt, negatively comparing themselves to other clinicians, taking longer to make decisions, and questioning if they were bad psychologists. This lack of confidence in their ability to practise as a good psychologist led to reduced professional efficacy and performance; one participant reported having to take leave from work due to feeling at risk of practising unethically. Research supports this finding and states having self-efficacy at work is hugely influential in protecting against burnout, even more so than autonomy (Schaufeli & Buunk, 1996). For psychologists working in the public sector, self-efficacy can be hard to achieve as they are more likely to work with severe clients with complex issues such as substance abuse, psychotic behaviour, and personality disorders where treatment can be arduous (Ackerley et al., 1988). Research confirms that psychologists treating these types of patients are more likely to experience greater self-doubt and personal depletion (Hellman & Morrison, 1987).

Results of this study revealed that for many participants being a psychologist was strongly connected to their identity, and feelings of self-doubt made them question ‘who would I be if not a psychologist?’ All participants reported considering changing careers or

roles due to their burnout; this was a devastating choice to grapple with after investing immense time and energy into their careers, with some describing this change as an 'existential crisis'. Research shows physicians and psychologists commonly blend their professional and personal identities due to the time and effort put into becoming a professional, and the amount of cross over between their personal and professional life (Lenoir et al., 2021; Schubert et al., 2023). Additionally, research suggests that turnover is twice as common within the public health sector compared to the private sector (Johnson et al., 2018), showing a strong link between clinicians being burnt out and wanting to leave their jobs (Acker, 2012; Chambers & Frampton, 2022).

Results showed that burnout impacted the quality of care participants were able to provide their clients. Participants reported having less time and energy for client prep work, compassion fatigue, reduced empathy, and less hope for clients. Due to organisational demands, some reported having to apply a less personalised and more 'cookie cutter' approach to care. This created an ethical dilemma for participants attempting to uphold their responsibilities as psychologists but struggling to do so while trying to meet organisational targets. This is seen in the article by Chambers and Frampton (2022) where psychiatrists reported having to discharge patients before they were ready and feeling as though they were setting them up to fail. Studies support the finding that burnout can negatively impact clinicians quality of care (Salyers et al., 2015; Vivolo et al., 2022; Yang & Hayes, 2020) through having less empathy for clients, poorer listening skills, poorer rapport building (Jun et al., 2021), rushed consultations, and being more likely to refer onto someone else (Hall, 2001; Salyers et al., 2015). Often leading to poorer patient outcomes and slower treatment progress (Yang & Hayes, 2020).

Despite client engagement being challenging at times, this study found that participant's passion for their client work was strong and acted as a 'saving grace' during times of burnout. For many participants, despite their exhaustion, they focused all of their effort into their client sessions. This finding was expected as research shows psychologists highly value their client work, and in many cases, the high administrative responsibilities and workload contributes more to their burnout than client engagement (Chambers et al., 2016; Kumar et al., 2011; Rupert & Morgan, 2005; Vivolo et al., 2022). Research has suggested that many psychologists in the public sector struggle with high administrative responsibilities and feel it is a waste of their clinical skill set (Blayney & Kercher, 2023; Chambers et al., 2016; Every-Palmer et al., 2024; Fischer et al., 2007; Vivolo et al., 2022). This study revealed similar findings, as participants spoke about their frustrations with long report writing and insufficient dated systems. This highlights a need for more efficient systems within the public sector or administrative support so that psychologists have more availability for client work.

Social Connection and Self-Care for Recovery

This study found that social connection was a strong protective factor for those experiencing burnout. Despite initial dread, many participants found it helpful at work to reach out to managers, colleagues, and supervisors for support. This is consistent with the literature that states a supportive workplace environment is very important in preventing and improving burnout (Blayney & Kercher, 2023; Fischer et al., 2007; Maslach & Leiter, 2016; Vivolo et al., 2022). Positive collegial relationships can provide emotional support following stressful events, guidance for decision making, and peer review (Reid et al., 2014). It can also contribute to better job satisfaction, lower turnout rates, and improved exhaustion levels and personal accomplishment; which are all factors that protect against burnout (Ducharme et al., 2007; Fernet et al., 2010; Yang & Hayes, 2020). Additionally, having adequate supervision is another important part of preventing burnout (Vivolo et al., 2022; Yang & Hayes, 2020). This

is because supervisors can help professionals work through feelings of self-doubt that often accompany burnout, ensuring it does not interfere with their clinical competency and client care. A New Zealand study showed that 70% of physicians reported needing support following mistakes, 72% reported needing to talk to someone about their mistakes, and 74% reported needing validation around their decisions (Bruce et al., 2005). This study also found that seeking support from loved ones was helpful for burnout recovery. Some spoke about sharing experiences with friends or past colleagues and were surprised to learn they had been through similar challenges which was validating to know they were not alone. Research supports this as connecting with loved ones is proven to reduce stress and improve wellbeing (Hamaideh, 2011; Maslach, 2017; Maslach & Goldberg, 1998).

This study found that self-care was an important protective factor for burnout. Many participants realised after they burnt out the importance of prioritising themselves at home in order to be good psychologists at work. Self-care strategies included maintaining clear worklife boundaries, spending time with loved ones, prioritising physical and mental health, and making time for hobbies. This is consistent with the research that states self-care is crucial for keeping one's mind and body equipped to handle challenges such as burnout (Maslach, 2017). Establishing workplace boundaries is critical for reducing burnout and is the first step in ensuring one has enough time for self-care and personal life (Blayney & Kercher, 2023; Fischer et al., 2007; Maslach & Goldberg, 1998; Morse et al., 2012). Exercise has been shown to be hugely beneficial, reducing burnout levels by over half in a randomised control trial, as well as improving stress, emotional exhaustion, and personal accomplishment (Bretland & Thorsteinsson, 2015). Self-care is an example of an individual-level intervention where the person is responsible for improving their burnout (Maslach & Goldberg, 1998) although individual level interventions can be very helpful, they do have some limitations; those who are burnt out may struggle with implementing self-care due to exhaustion and

depressive symptoms. Additionally, it does not target the root cause of burnout which is likely organisational factors (Hätinen et al., 2009; Maslach, 2017).

Despite collegial support being a major protective factor, many participants in this study reported this was lacking in their workplace, with a strong emphasis on participants taking personal responsibility for their burnout without managers addressing or acknowledging the systemic issues that were causing it. Research suggests burnout is viewed as an individual problem, despite there being stronger evidence for the effectiveness of organisational-level interventions over individual interventions (Hätinen et al., 2009; Maslach, 2017), these are not typically implemented due to the time, cost, and efforts required from the organisation (Maslach et al., 2001). Participants felt that a more collegial workplace would improve burnout, including more understanding and proactive managers, a focus on team bonding exercises, and prioritising peer support and teamwork amongst colleagues. This is supported by the literature which states organisational level interventions such as improving supervision, managerial support, collegial bonding, decreasing workload, and increasing role autonomy have been found to be efficient in reducing burnout (Hätinen et al., 2009; Maslach, 2017; Panagioti et al., 2017).

Participants felt there needed to be more awareness around burnout in the workplace so that it is normalised and people feel comfortable reaching out for help. Many felt alone in their burnout, not being aware of what it is, not knowing to look out for signs, not hearing people openly discuss it in the workplace, and thus not feeling comfortable seeking support from others. Research has shown that burnout is not always understood by workplaces and managers and therefore, this reduces the likelihood of employees seeking help (Putnik et al., 2011). This provides a helpful recommendation to workplaces to reduce burnout among staff.

Strengths

A strength of this study is that using a qualitative approach allowed us to hear experiences and stories from psychologists first hand and to give them a voice in a system where it is commonly unheard. Some participants after the interview shared how it was therapeutic to be able to share their experiences and how it helped them to learn more about their own burnout.

Another strength of this study is that it covers an issue that is relevant in the public sector currently and impacts many psychologists and other professionals within the sector. This study not only looks at the causes and consequences of burnout but also the coping strategies and changes that participants felt would help to improve burnout, therefore this produces recommendations for change that could be helpful for both organisations and psychologists. Although burnout has been widely researched globally, there are limited New Zealand studies therefore, this study addresses a research gap that would benefit from more investigation.

Limitations

This study had some limitations that should be acknowledged and considered when interpreting the results. A limitation of this study is that the population sample lacked gender and occupational diversity which may have resulted in low generalisability. The population sample consisted of mostly females (12 out of 14), this is consistent with the current state of burnout research where majority of research participants are female (Hall, 2001; Nicholls et al., 2021; Stone et al., 2021; Zarei et al., 2019), reasons for this may be that women are more likely to report their burnout compared to men (Purvanova & Muros, 2010). Research shows burnout can present differently among men and women, therefore, this should be considered when interpreting the results of this study. Additionally, most of the sample population (10

out of 14) were working in a forensic setting. This means that the results may not be generalisable across all psychologists and reflect experiences of working in a particular public sector. Furthermore, I only interviewed those working in the public sector, since turnover is common among burnt out professionals (Johnson et al., 2018), I can hypothesise that some psychologists who have experienced burnout may have moved to the private sector, and would not have been included in the sample.

Another weakness is that through the use of qualitative thematic analysis, the analysis was subject to potential researcher bias. My own experience of burnout may have influenced how I coded and developed themes as I may have been more likely to choose pieces of information that resonated with me, whereas a different researcher may have interpreted the data differently (Clarke & Braun, 2013). I also acknowledge that I as the lead researcher am a university student and not a registered psychologist, since my own experience of burnout comes from my work in a separate profession this may have caused me to misinterpret the clinical experiences the participants shared. Although researcher bias comes with qualitative research, the findings were consistent with many other similar New Zealand studies (Blayney & Kercher, 2023; Fischer et al., 2007; Vivolo et al., 2022) therefore, I may assume this bias did not have a large impact on the results of the study.

Another limitation is possible response bias from the participants. Especially when discussing the causes of burnout, many participants shared negative feedback about their workplaces that if exposed, could impact their role and relationship with their superiors. This meant that participants may have refrained from sharing sensitive information due to the risk of this being shared. To mitigate this confidentiality and anonymity were prioritised throughout the data collection and writing stages of this thesis.

Implications

The results of this study have both theoretical and practical implications. Theoretically, this study contributes to the wider literature on burnout. Although this is a widely researched topic globally there are very few studies that investigate burnout for mental health professionals in New Zealand (Blayney & Kercher, 2023; Chambers & Frampton, 2022; Fischer et al., 2007; Kumar et al., 2011). Since the need for mental health support is large in New Zealand (Mulder et al., 2017) and we do not have enough available psychologists to meet this need (Every-Palmer et al., 2024; Fischer et al., 2007; Kumar et al., 2011) research in this area is important for understanding how to prevent burnout to improve professionals' quality of life and retain psychologists in the public sector.

The results of this study contribute to the wider literature that brings attention to the many challenges faced by mental health professionals working in the public sector and how these challenges leave them vulnerable to burnout (Every-Palmer et al., 2024; Fischer et al., 2007; Kumar et al., 2011). Burnout is a serious issue that has negative consequences for professionals, public health organisations, and clients. This study suggests many areas for improvement that organisations should address to reduce and prevent burnout, such as listening to feedback from professionals about systematic issues and working to address these, increasing awareness and understanding of burnout within the workplace, encouraging more supportive managers and superiors, and prioritising collegial connection and peer support.

Conclusion

Through a qualitative thematic approach, this study explored the causes, consequences, and coping strategies for burnout among 14 psychologists working in the public sector in New Zealand. The results were consistent with much of the research in the burnout space. This study shed light on the many systemic and environmental challenges in the public sector, particularly a lack of resources that psychologists face which contributes to their burnout. Experiencing burnout was debilitating for many and led to numerous negative consequences for their personal well-being and professional efficacy and identity. Connecting with others and prioritising self-care helped improve burnout, nonetheless, participants highlighted a need for workplaces to take accountability for their own role in contributing to burnout, and through improving awareness and understanding within the workplace this could encourage those struggling to reach out. Recommendations from this study are for organisations to reflect on ways they can help improve their internal systems to reduce workload and stress for employees and prevent burnout. They should also aim to improve awareness and understanding of burnout within the workplace through more supportive managers and superiors, fostering closer relationships between colleagues, and promoting help-seeking for those struggling. I hope this study helps to connect those who have experienced burnout and to assure them they are not alone, burnout can impact any psychologist, regardless of personality, experience, and work habits therefore, sharing experiences with others is an important first step for reducing the stigma associated with burnout and preventing it in its early stages.

References

Acker, G. M. (2012). Burnout among mental health care providers. *Journal of Social Work*, *12*(5), 475–490. https://doi.org/10.1177/1468017310392418

Ackerley, G. D., Burnell, J., Holder, D. C., & Kurdek, L. A. (1988). Burnout among licensed psychologists. *Professional Psychology: Research and Practice*, *19*(6). https://doi.org/10.1037/0735-7028.19.6.624

Ahola, K., Honkonen, T., Isometsä, E., Kalimo, R., Nykyri, E., Aromaa, A., & Lönnqvist, J. (2005). The relationship between job-related burnout and depressive disorders—results from the Finnish Health 2000 Study. *Journal of Affective Disorders*, *88*(1), 55–62. https://doi.org/10.1016/j.jad.2005.06.004

Ahola, K., Honkonen, T., Isometsä, E., Kalimo, R., Nykyri, E., Koskinen, S., Aromaa, A., & Lönnqvist, J. (2006). Burnout in the general population. *Social Psychiatry and Psychiatric Epidemiology*, *41*(1), 11–17. https://doi.org/10.1007/s00127-005-0011-5

Ahola, K., Kivimäki, M., Honkonen, T., Virtanen, M., Koskinen, S., Vahtera, J., & Lönnqvist, J. (2008). Occupational burnout and medically certified sickness absence: A population-based study of Finnish employees. *Journal of Psychosomatic Research*, *64*(2), 185–193. https://doi.org/10.1016/j.jpsychores.2007.06.022

Akova, İ., Kiliç, E., & Özdemir, M. E. (2022). Prevalence of burnout, depression, anxiety, stress, and hopelessness among healthcare workers in COVID-19 pandemic in Turkey. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, *59*, 004695802210796. https://doi.org/10.1177/00469580221079684

Alarcon, G., Eschleman, K. J., & Bowling, N. A. (2009). Relationships between personality variables and burnout: A meta-analysis. *Work & Stress*, *23*(3), 244–263. https://doi.org/10.1080/02678370903282600

Awa, W. L., Plaumann, M., & Walter, U. (2010). Burnout prevention: A review of intervention programs. *Patient Education and Counseling*, *78*(2), 184–190. https://doi.org/10.1016/j.pec.2009.04.008

Beautrais, A. L., Elisabeth Wells, J., Mcgee, M. A., & Oakley Browne, M. A. (2006). Suicidal behaviour in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian & New Zealand Journal of Psychiatry*, *40*(10), 896–904. https://doi.org/10.1080/j.1440-1614.2006.01909.x

Bianchi, R., Schonfeld, I. S., & Laurent, E. (2015). Burnout–depression overlap: A review. *Clinical Psychology Review*, *36*, 28–41. https://doi.org/10.1016/j.cpr.2015.01.004

Blayney, M., & Kercher, A. (2023). Psychologists' experiences of burnout in Aotearoa, New Zealand: A nationwide qualitative survey. *In NZJP* (Vol. 52, Issue 1).

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bretland, R. J., & Thorsteinsson, E. B. (2015). Reducing workplace burnout: The relative benefits of cardiovascular and resistance exercise. *PeerJ*, *3*, e891. https://doi.org/10.7717/peerj.891

Bruce, S. M., Conaglen, H. M., & Conaglen, J. V. (2005). Burnout in physicians: A case for peer-support. *Internal Medicine Journal*, *35*(5), 272–278. https://doi.org/10.1111/j.1445-5994.2005.00782.x

Chambers, C. N. L., & Frampton, C. M. A. (2022). Burnout, stress and intentions to leave work in New Zealand psychiatrists; A mixed methods cross sectional study. *BMC Psychiatry*, *22*(1), 380. https://doi.org/10.1186/s12888-022-03980-6

Chambers, C. N. L., Frampton, C. M. A., Barclay, M., & McKee, M. (2016). Burnout prevalence in New Zealand's public hospital senior medical workforce: A crosssectional mixed methods study. *BMJ Open*, *6*(11). https://doi.org/10.1136/bmjopen-2016-013947

Clarke, V., & Braun, V. (2013). Successful qualitative research: A practical guide for beginners. *QMiP Bulletin*, *1*(21). https://doi.org/10.53841/bpsqmip.2016.1.21.48

Coates, D. D., & Howe, D. (2015). The design and development of staff wellbeing initiatives: Staff stressors, burnout and emotional exhaustion at children and young people's mental health in Australia. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*(6), 655–663. https://doi.org/10.1007/s10488-014-0599-4

Cooper, C. L., & Campbell Quick, J. (2017). The handbook of stress and health: A guide to research and practice. *The Handbook of Stress and Health*.

Cresswell, J. W. (1999). Qualitative Inquiry Research Design. In *Sage Publication* (Vol. 77, Issue 4).

Crow, G., Wiles, R., Heath, S., & Charles, V. (2006). Research ethics and data quality: The implications of informed consent. *International Journal of Social Research Methodology*, *9*(2), 83–95. https://doi.org/10.1080/13645570600595231

Demerouti, E., & Bakker, A. B. (2007). The Oldenburg Burnout Inventory: A good alternative to measure burnout and engagement. *Handbook of Stress and Burnout in Healthcare*, *January*.

Demerouti, E., Nachreiner, F., Bakker, A. B., & Schaufeli, W. B. (2001). The job demandsresources model of burnout. *Journal of Applied Psychology*, *86*(3). https://doi.org/10.1037/0021-9010.86.3.499

Demerouti, E. (1999). *Burnout: Eine Folge konkreter Arbeitsbedingungen bei Dienstleistungs-und Produktionstätigkeiten*. Lang.

Desart, S., & Witte, H. De. (2019). Burnout 2.0 – A new look at the conceptualisation of burnout. *The Fun and Frustration of Modern Working Life: Contributions from an Occupational Health Psychology Perspective*.

Devilly, G. J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *Australian & New Zealand Journal of Psychiatry*, *43*(4), 373–385. https://doi.org/10.1080/00048670902721079

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education*, *40*(4), 314–321. https://doi.org/10.1111/j.1365-2929.2006.02418.x

Dreison, K. C., Luther, L., Bonfils, K. A., Sliter, M. T., McGrew, J. H., & Salyers, M. P. (2018). Job burnout in mental health providers: A meta-analysis of 35 years of intervention research. *Journal of Occupational Health Psychology*, *23*(1), 18–30. https://doi.org/10.1037/ocp0000047

Ducharme, L. J., Knudsen, H. K., & Roman, P. M. (2007). Emotional exhaustion and turnover in intention in huma service occupations: the protective role of coworker support. *Sociological Spectrum*, *28*(1), 81–104. https://doi.org/10.1080/02732170701675268

Edú-Valsania, S., Laguía, A., & Moriano, J. A. (2022). Burnout: A review of theory and measurement. *International Journal of Environmental Research and Public Health*, *19*(3), 1780. https://doi.org/10.3390/ijerph19031780

Every-Palmer, S., Grant, M. L., Thabrew, H., Hansby, O., Lawrence, M., Jenkins, M., &

Romans, S. (2024). Not heading in the right direction: Five hundred psychiatrists' views on resourcing, demand, and workforce across New Zealand mental health services. *Australian & New Zealand Journal of Psychiatry*, *58*(1), 82–91. https://doi.org/10.1177/00048674231170572

Fernet, C., Gagné, M., & Austin, S. (2010). When does quality of relationships with coworkers predict burnout over time? The moderating role of work motivation. *Journal of Organizational Behavior*, *31*(8), 1163–1180. https://doi.org/10.1002/job.673

Figueiredo-Ferraz, H., Gil-Monte, P. R., & Grau-Alberola, E. (2013). Psychometric properties of the "Spanish Burnout Inventory" (SBI): Adaptation and validation in a Portuguese-speaking sample. *European Review of Applied Psychology*, *63*(1), 33–40. https://doi.org/10.1016/j.erap.2012.08.003

Figueiredo, S., Arrieux, J., Abdallah, S., McCall, T. C., Koch, U., & Oliveira, E. (2024). Can the different versions of the Shirom-Melamed Burnout Measure be used to measure burnout among healthcare professionals? A systematic review of psychometric properties. *Journal of Patient-Reported Outcomes*, *8*(1), 108. https://doi.org/10.1186/s41687-024-00788-8

Fischer, J., Kumar, S., & Hatcher, S. (2007). What makes psychiatry such a stressful profession? A qualitative study. *Australasian Psychiatry*, *15*(5), 417–421. https://doi.org/10.1080/10398560701439699

Fitzgerald, J., Galyer, K., & Ryan, J. (2009). The evaluation of a brief mental health therapy initiative in primary care: Is there a role for psychologists? *New Zealand Journal of Psychology*, *38*(1).

Freudenberger, H. J. (1974). Staff Burn-Out. *Journal of Social Issues*, *30*(1), 159–165. https://doi.org/10.1111/j.1540-4560.1974.tb00706.x

Gubrium, J., & Holstein, J. (2001). *Handbook of Interview Research*. SAGE Publications, Inc. https://doi.org/10.4135/9781412973588

Halbesleben, J. R. B., & Demerouti, E. (2005). The construct validity of an alternative measure of burnout: Investigating the English translation of the Oldenburg Burnout Inventory. *Work & Stress*, *19*(3), 208–220. https://doi.org/10.1080/02678370500340728

Hall, L. (2001). Burnout: Results of an empirical study of New Zealand nurses. *Contemporary Nurse*, *11*(1), 71–83. https://doi.org/10.5172/conu.11.1.71

Hall, L. H., Johnson, J., Heyhoe, J., Watt, I., Anderson, K., & O'Connor, D. B. (2020). Exploring the impact of primary care physician burnout and well-being on patient care: A focus group study. *Journal of Patient Safety*, *16*(4), e278–e283. https://doi.org/10.1097/PTS.0000000000000438

Hamaideh, S. H. (2011). Burnout, social support, and job satisfaction among Jordanian mental health nurses. *Issues in Mental Health Nursing*, *32*(4), 234–242. https://doi.org/10.3109/01612840.2010.546494

Hammond, T. E., Crowther, A., & Drummond, S. (2018). A thematic inquiry into the burnout experience of Australian solo-practicing clinical psychologists. *Frontiers in Psychology*, *8*. https://doi.org/10.3389/fpsyg.2017.01996

Hätinen, M., Kinnunen, U., Mäkikangas, A., Kalimo, R., Tolvanen, A., & Pekkonen, M. (2009). Burnout during a long-term rehabilitation: Comparing low burnout, high burnout – benefited, and high burnout – not benefited trajectories. *Anxiety, Stress & Coping*, *22*(3), 341–360. https://doi.org/10.1080/10615800802567023

Health and Disability Commissioner. (2018) *Mental health commissioner's monitoring and advocacy report.* https://www.hdc.org.nz/making-a-complaint/mental-healthaddictions/mental-health-commissioners-monitoring-and-advocacy-report-2018/

Hellman, I. D., & Morrison, T. L. (1987). Practice setting and type of caseload as factors in psychotherapist stress. *Psychotherapy*, *24*(3). https://doi.org/10.1037/h0085735

Honkonen, T., Ahola, K., Pertovaara, M., Isometsä, E., Kalimo, R., Nykyri, E., Aromaa, A., & Lönnqvist, J. (2006). The association between burnout and physical illness in the general population—results from the Finnish Health 2000 Study. *Journal of Psychosomatic Research*, *61*(1), 59–66. https://doi.org/10.1016/j.jpsychores.2005.10.002

Ilife, G., & Steed, L. G. (2000). Exploring the counsellor's experience of working with perpetrators and survivors of domestic violence. *Journal of Interpersonal Violence*, *15*(4), 393–412. https://doi.org/10.1177/088626000015004004

Innstrand, S. T., Langballe, E. M., Falkum, E., & Aasland, O. G. (2011). Exploring within- and between-gender differences in burnout: Eight different occupational groups. *International Archives of Occupational and Environmental Health*, *84*(7), 813–824. https://doi.org/10.1007/s00420-011-0667-y

Jaworska-Burzyńska, L., Kanaffa-Kilijańska, U., Przysiężna, E., & Szczepańska-Gieracha, J. (2016). The role of therapy in reducing the risk of job burnout – A systematic review of literature. *Archives of Psychiatry and Psychotherapy*, *18*(4), 43–52. https://doi.org/10.12740/APP/65815

Johnson, J., Hall, L. H., Berzins, K., Baker, J., Melling, K., & Thompson, C. (2018). Mental healthcare staff well-being and burnout: A narrative review of trends, causes, implications, and recommendations for future interventions. *International Journal of Mental Health Nursing*, *27*(1), 20–32. https://doi.org/10.1111/inm.12416

Jun, J., Ojemeni, M. M., Kalamani, R., Tong, J., & Crecelius, M. L. (2021). Relationship between nurse burnout, patient and organizational outcomes: Systematic review. *International Journal of Nursing Studies*, *119*, 103933. https://doi.org/10.1016/j.ijnurstu.2021.103933

Kakiashvili, T., Leszek, J., & Rutkowski, K. (2013). The medical perspective on burnout. *International Journal of Occupational Medicine and Environmental Health*, *26*(3). https://doi.org/10.2478/s13382-013-0093-3

Karasek, R. A. (1979). Job demands, job decision latitude, and mental strain: Implications for Job redesign. *Administrative Science Quarterly*, *24*(2), 285. https://doi.org/10.2307/2392498

Kristensen, T. S., Borritz, M., Villadsen, E., & Christensen, K. B. (2005). The Copenhagen Burnout Inventory: A new tool for the assessment of burnout. *Work & Stress*, *19*(3), 192–207. https://doi.org/10.1080/02678370500297720

Kumar, S., Hatcher, S., Dutu, G., Fischer, J., & Ma'u, E. (2011). Stresses experienced by psychiatrists and their role in burnout: A national follow-up study. *International Journal of Social Psychiatry*, *57*(2). https://doi.org/10.1177/0020764009341211

Lacey, C., Huria, T., Beckert, L., Gilles, M., & Pitama, S. (2011). The hui process: A framework to enhance the doctor-patient relationship with Māori. *New Zealand Medical Journal*, *124*(1347).

Lazarus, R. S. (1966). *Psychological stress and the coping process.* McGraw-Hill.

Leiter, M. P., & Maslach, C. (2018). Interventions to prevent and alleviate burnout. *Current Issues in Work and Organizational Psychology*. https://doi.org/10.4324/9780429468339

Lenoir, A.-L., De Troyer, C., Demoulin, C., Gillain, I., & Bayot, M. (2021). Challenges in treating physician burnout: The psychologist's perspective. *La Presse Médicale Open*, *2*, 100006. https://doi.org/10.1016/j.lpmope.2021.100006

Li, Y., Lai, C. Y., Friedrich, B., Liu, C., & Popkin, J. H. (2023). The Association of hobbies and leisure activities with physician burnout and disengagement. *Journal of Wellness*, *5*(1). https://doi.org/10.55504/2578-9333.1160

Lim, N., Kim, E. K., Kim, H., Yang, E., & Lee, S. M. (2010). Individual and work-related factors influencing burnout of mental health professionals: A meta-analysis. *Journal of Employment Counseling*, *47*(2), 86–96. https://doi.org/10.1002/j.2161-1920.2010.tb00093.x

Lockett, H., Lai, J., Tuason, C., Jury, A., & Fergusson, D. (2018). Primary healthcare utilisation among adults with mood and anxiety disorders: An analysis of the New Zealand Health Survey. *Journal of Primary Health Care*, *10*(1), 68. https://doi.org/10.1071/HC17077

Lu, S., Zhang, L., Klazinga, N., & Kringos, D. (2020). More public health service providers are experiencing job burnout than clinical care providers in primary care facilities in China. *Human Resources for Health*, *18*(1), 95. https://doi.org/10.1186/s12960-020-00538-z

Malach-Pines, A. (2005). The Burnout Measure, short version. *International Journal of*

Stress Management, *12*(1), 78–88. https://doi.org/10.1037/1072-5245.12.1.78

Maslach, C. (1993). Burnout: A multidimensional perspective. *Professional Burnout* (1st ed., Vol. 33, pp. 19–32). Routledge. https://doi.org/10.4324/9781315227979-3

Maslach, C. (2017). Finding solutions to the problem of burnout. *Consulting Psychology Journal: Practice and Research*, *69*(2), 143–152. https://doi.org/10.1037/cpb0000090

Maslach, C., & Goldberg, J. (1998). Prevention of burnout: New perspectives. *Applied and Preventive Psychology*, *7*(1), 63–74. https://doi.org/10.1016/S0962-1849(98)80022-X

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior*, *2*(2), 99–113. https://doi.org/10.1002/job.4030020205

Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry*, *15*(2), 103–111. https://doi.org/10.1002/wps.20311

Maslach, C., & Leiter, M. P. (2017). Understanding burnout. *The Handbook of Stress and Health* (pp. 36–56). John Wiley & Sons, Ltd. https://doi.org/10.1002/9781118993811.ch3

Maslach, C., & Schaufeli, W. B. (2018). Historical and conceptual development of burnout. *Professional Burnout*. https://doi.org/10.4324/9781315227979-1

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology*, *52*(1), 397–422. https://doi.org/10.1146/annurev.psych.52.1.397

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*(1), 131–149. https://doi.org/10.1007/BF00975140

McCormack, H. M., MacIntyre, T. E., O'Shea, D., Herring, M. P., & Campbell, M. J. (2018). The prevalence and causes of burnout among applied psychologists: A Systematic Review. *Frontiers in Psychology*, *9*. https://doi.org/10.3389/fpsyg.2018.01897

Melamed, S., Shirom, A., Toker, S., Berliner, S., & Shapira, I. (2006). Burnout and risk of cardiovascular disease: Evidence, possible causal paths, and promising research directions. *Psychological Bulletin*, *132*(3), 327–353. https://doi.org/10.1037/0033-2909.132.3.327

Montgomery, A. P., Azuero, A., & Patrician, P. A. (2021). Psychometric properties of Copenhagen Burnout Inventory among nurses. *Research in Nursing & Health*, *44*(2), 308–318. https://doi.org/10.1002/nur.22114

Moreau, E., & Mageau, G. A. (2012). The importance of perceived autonomy support for the psychological health and work satisfaction of health professionals: Not only supervisors count, colleagues too! *Motivation and Emotion*, *36*(3), 268–286. https://doi.org/10.1007/s11031-011-9250-9

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and it's remediation. *Administration and Policy in Mental Health and Mental Health Services Research*, *39*(5), 341–352. https://doi.org/10.1007/s10488-011-0352-1

Moss, J. (2021). *The Burnout Epidemic the Rise of Chronic Stress and how We Can Fix It* (First ebook edition.). Harvard Business Review Press.

Mulder, R., Rucklidge, J., & Wilkinson, S. (2017). Why has increased provision of psychiatric treatment not reduced the prevalence of mental disorder? *Australian & New*

Zealand Journal of Psychiatry, *51*(12), 1176–1177. https://doi.org/10.1177/0004867417727356

New Zealand College of Clinical Psychologists. (2016) *The Aotearoa New Zealand psychology workforce survey.* https://www.nzccp.co.nz/assets/Aotearoa-NZ-Psychology-Workforce-Survey-2016.pdf

New Zealand Psychologists Board. (2023) *Annual Report.* https://psychologistsboard.org.nz/wp-content/uploads/2024/04/Psychologists-Board-Ann-Rpt-2023I.pdf

Nicholls, M., Hamilton, S., Jones, P., Frampton, C., Anderson, N., Tauranga, M., Beck, S., Cadzow, A., Cadzow, N., Chiang, A., Fayerberg, E., Hayward, L., MacLean, A., McLeay, A., Moran, S., Muthu, A., Rogan, A., Rolton, N., Sagarin, M., … Selak, V. (2021). Workplace wellbeing in emergency departments in Aotearoa New Zealand 2020. *New Zealand Medical Journal*, *134*(1541).

O'Connor, K., Muller Neff, D., & Pitman, S. (2018). Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. *European Psychiatry*, *53*, 74–99. https://doi.org/10.1016/j.eurpsy.2018.06.003

Ogunsuji, O., Ogundipe, H., Adebayo, O., Oladehin, T., Oiwoh, S., Obafemi, O., Soneye, O., Agaja, O., Uyilawa, O., Efuntoye, O., Alatishe, T., Williams, A., Ilesanmi, O., & Atilola, O. (2022). Internal reliability and validity of Copenhagen Burnout Inventory and Oldenburg Burnout Inventory compared with Maslach Burnout Inventory among Nigerian resident doctors: A pilot study. *Dubai Medical Journal*, *5*(2), 89–95. https://doi.org/10.1159/000521376

Otter.ai. (2023). https://otter.ai

Panagioti, M., Panagopoulou, E., Bower, P., Lewith, G., Kontopantelis, E., Chew-Graham, C., Dawson, S., van Marwijk, H., Geraghty, K., & Esmail, A. (2017). Controlled interventions to reduce burnout in physicians. *JAMA Internal Medicine*, *177*(2), 195. https://doi.org/10.1001/jamainternmed.2016.7674

Parandeh, A., Ashtari, S., Rahimi-Bashar, F., Gohari-Moghadam, K., & Vahedian-Azimi, A. (2022). Prevalence of burnout among health care workers during coronavirus disease (COVID-19) pandemic: A systematic review and meta-analysis. *Professional Psychology: Research and Practice*, *53*(6), 564–573. https://doi.org/10.1037/pro0000483

Pines, A., & Aronson, E. (1988). *Career burnout: Causes and cures.* Free Press.

Pretorius, C., Chambers, D., & Coyle, D. (2019). Young people's online help-seeking and mental health difficulties: Systematic narrative review. *Journal of Medical Internet Research*, *21*(11), e13873. https://doi.org/10.2196/13873

Purvanova, R. K., & Muros, J. P. (2010). Gender differences in burnout: A meta-analysis. *Journal of Vocational Behavior*, *77*(2), 168–185. https://doi.org/10.1016/j.jvb.2010.04.006

Putnik, K., de Jong, A., & Verdonk, P. (2011). Road to help-seeking among (dedicated) human service professionals with burnout. *Patient Education and Counseling*, *83*(1), 49–54. https://doi.org/10.1016/j.pec.2010.01.004

Reid, J., Taylor-Moore, K., & Varona, G. (2014). Towards a social-structural model for understanding current disparities in Māori health and well-being. *Journal of Loss and Trauma*, *19*(6), 514–536. https://doi.org/10.1080/15325024.2013.809295

Rotenstein, L. S., Torre, M., Ramos, M. A., Rosales, R. C., Guille, C., Sen, S., & Mata, D. A.

(2018). Prevalence of burnout among physicians. *JAMA*, *320*(11), 1131. https://doi.org/10.1001/jama.2018.12777

Rucklidge, J. J., Darling, K. A., & Mulder, R. T. (2018). Addressing the treatment gap in New Zealand with more therapists – is it practical and will it work? *New Zealand Medical Journal* (Vol. 131, Issue 1487).

Rupert, P. A., & Kent, J. S. (2007). Gender and work setting differences in career-sustaining behaviours and burnout among professional psychologists. *Professional Psychology: Research and Practice*, *38*(1), 88–96. https://doi.org/10.1037/0735-7028.38.1.88

Rupert, P. A., & Morgan, D. J. (2005). Work setting and burnout among professional psychologists. *Professional Psychology: Research and Practice*, *36*(5), 544–550. https://doi.org/10.1037/0735-7028.36.5.544

Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: Implications for the mental health of health workers? *Clinical Psychology Review*, *23*(3), 449–480. https://doi.org/10.1016/S0272-7358(03)00030-8

Salvagioni, D. A. J., Melanda, F. N., Mesas, A. E., González, A. D., Gabani, F. L., & Andrade, S. M. de. (2017). Physical, psychological and occupational consequences of job burnout: A systematic review of prospective studies. *PLOS ONE*, *12*(10), e0185781. https://doi.org/10.1371/journal.pone.0185781

Salyers, M. P., Flanagan, M. E., Firmin, R., & Rollins, A. L. (2015). Clinicians' perceptions of how burnout affects their work. *Psychiatric Services*, *66*(2), 204–207. https://doi.org/10.1176/appi.ps.201400138

Santoft, F., Salomonsson, S., Hesser, H., Lindsäter, E., Ljótsson, B., Lekander, M., Kecklund, G., Öst, L.-G., & Hedman-Lagerlöf, E. (2019). Mediators of change in cognitive

behaviour therapy for clinical burnout. *Behavior Therapy*, *50*(3), 475–488. https://doi.org/10.1016/j.beth.2018.08.005

Scarnera, P., Bosco, A., Soleti, E., & Lancioni, G. E. (2009). Preventing burnout in mental health workers at interpersonal level: An Italian pilot study. *Community Mental Health Journal*, *45*(3), 222–227. https://doi.org/10.1007/s10597-008-9178-z

Schaufeli, W. B. (2017). Burnout: A short socio-cultural history. *Burnout, Fatigue, Exhaustion: An Interdisciplinary Perspective on a Modern Affliction*. https://doi.org/10.1007/978-3-319-52887-8_5

Schaufeli, W. B., & Buunk, B. P. (1996). *Professional Burnout Schaufeli 1996*. 1–299.

Schaufeli, W. B., Desart, S., & De Witte, H. (2020). Burnout Assessment Tool (BAT)—development, validity, and reliability. *International Journal of Environmental Research and Public Health*, *17*(24), 9495. https://doi.org/10.3390/ijerph17249495

Schaufeli, W. B., Leiter, M. P., & Maslach, C. (2009). Burnout: 35 years of research and practice. *Career Development International*, *14*(3), 204–220. https://doi.org/10.1108/13620430910966406

Schaufeli, W. B., Maslach, C., Leiter, M. P., & Jackson, S. E. (1996). Maslach Burnout Inventory - General Survey (MBI-GS). *MBI Manual*, *January*.

Schaufeli, W., & Enzmann, D. (2020). The burnout companion to study and practice: A critical analysis. *CRC Press.* https://doi.org/10.1201/9781003062745

Schmitz, N., Kruse, J., & Kugler, J. (2004). The association between physical exercises and health-related quality of life in subjects with mental disorders: Results from a crosssectional survey. *Preventive Medicine*, *39*(6), 1200–1207. https://doi.org/10.1016/j.ypmed.2004.04.034

Schubert, S., Buus, N., Monrouxe, L. V., & Hunt, C. (2023). The development of professional identity in clinical psychologists: A scoping review. *Medical Education*, *57*(7), 612–626. https://doi.org/10.1111/medu.15082

Schutte, N., Toppinen, S., Kalimo, R., & Schaufeli, W. B. (2000). The factorial validity of the Maslach Burnout Inventory-General Survey (MBI-GS) across occupational groups and nations. *Journal of Occupational and Organizational Psychology*, *73*(1). https://doi.org/10.1348/096317900166877

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*, e8. https://doi.org/10.1017/S2045796020001134

Simionato, G. K., & Simpson, S. (2018). Personal risk factors associated with burnout among psychotherapists: A systematic review of the literature. *Journal of Clinical Psychology*, *74*(9), 1431–1456. https://doi.org/10.1002/jclp.22615

Steed, L. G., & Downing, R. (1998). A phenomenological study of vicarious traumatisation amongst psychologists and professional counsellors working in the field of sexual abuse/assault. *Australasian Journal of Disaster and Trauma Studies*, *2*(2).

Stone, K. W., Kintziger, K. W., Jagger, M. A., & Horney, J. A. (2021). Public health workforce burnout in the COVID-19 response in the U.S. *International Journal of Environmental Research and Public Health*, *18*(8), 4369. https://doi.org/10.3390/ijerph18084369

Swider, B. W., & Zimmerman, R. D. (2010). Born to burnout: A meta-analytic path model of personality, job burnout, and work outcomes. *Journal of Vocational Behavior*, *76*(3),

487–506. https://doi.org/10.1016/j.jvb.2010.01.003

Temitope, K. M., & Williams, M. W. M. (2015). Secondary traumatic stress, burnout and the role of resilience in New Zealand counsellors. *New Zealand Journal of Counselling*, *35*(1), 1–21.

Te Whatu Ora. (2020). *How the health system works*. https://www.wcdhb.health.nz/yourhealth/how-the-health-system-works/

Dam, A. (2021). A clinical perspective on burnout: Diagnosis, classification, and treatment of clinical burnout. *European Journal of Work and Organizational Psychology*, *30*(5), 732–741. https://doi.org/10.1080/1359432X.2021.1948400

Vanheule, S., & Verhaeghe, P. (2005). Professional burnout in the mirror: A qualitative study from a Lacanian perspective. *Psychoanalytic Psychology*, *22*(2). https://doi.org/10.1037/0736-9735.22.2.285

Vivolo, M., Owen, J., & Fisher, P. (2022). Psychological therapists' experiences of burnout: A qualitative systematic review and meta-synthesis. *Mental Health & Prevention*, 200253. https://doi.org/10.1016/j.mhp.2022.200253

Vredenburgh, L. D., Carlozzi, A. F., & Stein, L. B. (1999). Burnout in counselling psychologists: Type of practice setting and pertinent demographics. *Counselling Psychology Quarterly*, *12*(3), 293–302. https://doi.org/10.1080/09515079908254099

Williams, M. W., Haarhoff, B., & Vertongen, R. (2017). Mental health in Aotearoa New Zealand: Rising to the challenge of the fourth wave? *New Zealand Journal of Psychology*, *46*(2), 16–22.

Winwood, P. C., & Winefield, A. H. (2004). Comparing two measures of burnout among dentists in Australia. *International Journal of Stress Management*, *11*(3), 282–289. https://doi.org/10.1037/1072-5245.11.3.282

World Health Organisation. (2019). *Burn-out an occupational phenomenon: International classification of disease.* https://www.who.int/news/item/28-05-2019-burn-out-anoccupational-phenomenon-international-classification-of-diseases

Yanchus, N. J., Periard, D., & Osatuke, K. (2017). Further examination of predictors of turnover intention among mental health professionals. *Journal of Psychiatric and Mental Health Nursing*, *24*(1), 41–56. https://doi.org/10.1111/jpm.12354

Yang, Y., & Hayes, J. A. (2020). Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. *Psychotherapy*, *57*(3), 426–436. https://doi.org/10.1037/pst0000317

Zarei, Ahmadi, Sial, Hwang, Thu, & Usman. (2019). Prevalence of burnout among primary health care staff and its predictors: A study in Iran. *International Journal of Environmental Research and Public Health*, *16*(12), 2249. https://doi.org/10.3390/ijerph16122249

Appendix A: Email to Public Organisations

Good Morning,

I am one of the first year clinical psychology students at Waikato University. I am currently doing my masters on burnout among psychologists working in the public sector and I would be grateful for the opportunity to speak to you about this in more detail if you would like.

I am at the recruiting stage in my masters, looking for psychologists to take part in 1 interview to share their experiences of workplace burnout. If you have any colleagues who may be interested would you be able to share this information with them please.

I have attached a poster and information sheet with some more information about the study. If you or anyone else has any questions at all or would like to express their interest please contact me on Af308@students.waikato.ac.nz and we can arrange a phone call.

Thank you again, have a great day

Kind regards,
Alexis Fraser

Appendix B: Recruitment Poster

Research Participants Needed

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

HAVE YOU EXPERIENCED BURNOUT IN THE WORKPLACE?

This research is part of a Master's thesis conducted by Alexis Fraser, Supervised by Dr. Armon Tamatea. This project has been approved by the Human Research Ethics Committee - HREC(Health)2023 #14.

If so, I am interested in hearing about your experiences and how you managed it

If you are:

- A practising psychologist working full time or part time in the public sector
- Has practised as a psychologist for the past 2 years
- Has experienced aspects of burnout during your career

You are invited to take part in this study which will involve an **interview**

To express your interest/request more information please contact Alexis:
af308@students.waikato.ac.nz

Participation in this study is voluntary and responses are confidential for research purposes only

Appendix C: Participant Information Sheet

Participant Information Sheet

The Causes, Consequences, and Coping of Burnout Among Psychologists in New Zealand

Lead Researcher: **Alexis Fraser** Ethics Ref: **HREC(Health)2023#14**

Supervisor: **Dr. Armon Tamatea**

Share your experiences of workplace burnout within the public sector

You are invited to take part in a Master's thesis research project investigating psychologist's experiences of burnout. Many psychologists have experienced a level of burnout during their career, we are interested in understanding the causes of burnout, the implications of it, and interventions that could help prevent and improve burnout.

Researchers

My name is Alexis Fraser I am a Master's student at Waikato University currently completing my thesis on the experiences of burnout among psychologists in New Zealand. I am also in my first year of the Clinical Psychology programme at Waikato. This project is being supervised by Dr. Armon Tamatea clinical psychologist, lecturer, and researcher. I am interested in understanding how burnout impacts psychologists working in the public health sector.

Participation Process

I would like to invite you to participate in this research if you meet the following criteria:

- A registered practising psychologist working in the public sector
- Have practised as a psychologist for the past 2 years
- Have experienced some aspects of burnout throughout their psychology career

I am aiming to recruit **6-10** psychologists to complete a semi structured **interview**. This interview should take approximately **45 minutes – 1.5 hours** depending on each individual. Interviews will be recorded for the purpose of data analysis and all participants will be provided with a transcript of the interview afterwards. Interviews can be completed in person or over zoom.

During the interview I will be asking a range of questions related to the following areas:

- **Experiences and perceived causes of burnout:**
  What does burnout mean to you personally? how have you experienced burnout?
- **Implications of burnout:**
  How has burnout has impacted your professional and personal life?
- **Ways to prevent/manage burnout:**

What are some techniques you use to help manage or prevent burnout?

Data collection and confidentiality

Participation in this study is completely voluntary and participants are not required to answer any questions they do not want to at any time during the interview. Interviews will be recorded and data will be kept on a password protected laptop for the purposes of this research only. Only the lead researchers (Armon and Alexis will have access to this data). Directly after the interview participant's names will be replaced with a pseudonym to protect confidentiality. Participants will be provided with a transcript of their interview and they will be able to change their responses if they wish. Participants may withdraw their consent to participate any time up until **two weeks** after receiving your transcript. If participants wish to receive a brief summary of the results of this study when it is finished they may email me. Five years after the research is published all information and data will be safely destroyed by supervisor Dr Armon Tamatea.

Ethics Approval

This study was approved by the University of Waikato Human Resource Ethics Committee (Health) in May 2023. If you have any queries or concerns about the ethics of this study please contact humanethics@waikato.ac.nz

Researchers Contact Information

Researcher: Alexis Fraser
Af308@students.waikato.ac.nz

Supervisor: Dr. Armon Tamatea
Armon.tamatea@waikato.ac.nz

If you have any questions or concerns about this study please contact Alexis Fraser above and we would be happy to assist you.

Appendix D: Interview Guide

Semi-Structured Interview Questions for Master's Thesis

The Causes, Consequences, and Coping of Burnout Among Psychologists in New Zealand Prerequisites:

- To be a current practicing psychologist working for a NZ public organization
- Has been a practicing psychologist for 2+ years
- Working in a full-time role **Background:**

What is your name?

How old are you?

What ethnicity do you identify with?

Which gender do you identify with?

What is your current role title and place of work?

How long have you been working in your current role?

How long have you been a practicing psychologist for?

Experiences/Causes:

- Can you describe what the term 'burnout' means to you?

Info to give to participants: Burnout is described as involving 3 parts –1) Emotional exhaustion (having low energy, feeling worn out or easily fatigued); 2) Depersonalisation (feeling cynical, feeling detached from the job or clients, having negative thoughts or attitudes, irritability, and feeling withdrawn from the job or clients); and 3) Lack of accomplishment (decreased efficiency/productivity at work, struggling with coping, decreased morale)(Maslach & Leiter, 2016)

- Have you experienced any of these aspects of burnout described above at any stage in your career while working as a psychologist? If so, which aspect(s) have you experienced the most?
- What was this experience like for you?
- Has covid-19 impacted your level of burnout? If so in what ways?
- When and how did you realise you may be experiencing an aspect of burnout?
- Can you notice when your colleagues are burnt out? and if so what do you notice?
- Does working with colleagues who are burnt out impact your level of burnout?
- What aspects of your work do you believe contributed to your burnout the most? - Do you think being exposed to traumatic material from clients impacts your health and

wellbeing? If yes, in what ways? Do you think this exposure increases your risk of developing burnout?

- Research has found mental health practitioners have higher rates of burnout compared to other professionals, why do you think this is?

Implications of burnout:

Personal

- Do you feel that your experience of burnout has impacted your mental health and/or well-being? If so, how?- Do you feel that your experience of burnout has impacted you physically? For example some people experience muscle pains/intestinal issues
- Do you feel that your experience of burnout has impacted your personal life? For example your friendships/relationships/parental responsibilities/hobbies/daily routines/social events. If so, how?

Professional

- Do you feel that your experience of burnout has impacted your ability to perform at work? if so, how?
- Have you taken a day off work or had to leave work due to your burnout before? - Do you feel that your burnout has impacted the quality of care you provide to your clients? If so, in what ways?
- Do you feel that your burnout has caused you to make mistakes at work? if so how? - Do you feel that your burnout has impacted your professional relationships with your colleagues/managers?

Ways to prevent/manage burnout:

- What do you do to protect yourself from developing burnout outside of work e.g at home?
- Are you able to notice early signs of burnout within yourself or do other people often have to tell you?
- What do you do to protect yourself from developing burnout at work?
- When you are experiencing burnout, what are some ways you manage this outside of work? e.g at home
- When you are experiencing burnout, what are some ways you manage this in your workplace?
- Are you aware of any interventions your workplace offers to prevent against or help manage burnout?

- Do you access these interventions? If yes: do you find them helpful? If no: why not?

- Do you find it difficult reaching out for support when you are burnout out? If yes:

why do you believe that is?

- How do you believe your workplace could protect staff from developing burnout?

And how could they better support staff who are burnout?

- What changes would you like to see made in the health sector as a whole to reduce

Appendix E: Participant Consent Form

Participant Consent Form

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

UNIVERSITY OF WAIKATO
FACULTY OF ARTS & SOCIAL SCIENCES

PARTICIPANT CONSENT FORM

Research Project: The Causes, Consequences, and Coping of Burnout Among Psychologists in New Zealand

Name of person interviewed: ____ _____

Please read the following items of consent and tick yes or no accordingly

Please Tick [✓] the appropriate box to give your consent to the following:	YES	NO
1. I have read and understand the Participant Information Sheet		
2. I have been given enough time to consider participating and have sought advice from friends/family if I needed		
3. I have had the opportunity to ask questions about the study if I needed and I know who and how to contact the researchers of this study if I have any further queries		
4. I understand that participating in this study is voluntary and will require an interview that may take up to 1.5 hours		
5. I understand that I may decline answering any questions I do not want to during the interview and can withdraw from the study up until 2 weeks after receiving a copy of my transcript		
6. I understand my participation will be confidential and that my name will be anonymised		
7. I understand I will be provided with a transcript of the interview where I can make any changes I see fit		
8. I would like a support person present at my interview		
9. I wish to receive a summary of the findings when this research is complete		

Declaration by Participant
I consent to take part in this study by signing below. If I have any ethical concerns I may contact the Human Research Ethics Committee at humanethics@waikato.ac.nz

Participants' name:_____

Signature:_____ Date:_____

Appendix F: Ethics Approval

The University of Waikato
Private Bag 3105
Gate 1, Knighton Road
Hamilton, New Zealand

Human Research Ethics Committee
Roger Moltzen
Telephone: +64021658119
Email:humanethics@waikato.ac.nz

THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

30 May 2023

Alexis Fraser
School of Psychology
DALPSS
By email: alexisfraser@outlook.co.nz

Dear Alexis

HREC(Health)2023#14 : The Causes, Consequences, and Coping of Burnout Among Psychologists in New Zealand

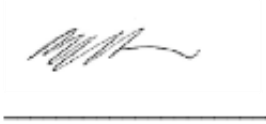
Thank you for your responses to the Committee feedback.

We are now pleased to provide formal approval for your project.

Please contact the Committee by email (humanethics@waikato.ac.nz) if you wish to make changes to your project as it unfolds, quoting your application number with your future correspondence. Any minor changes or additions to the approved research activities can be handled outside the monthly application cycle.

We wish you all the best with your research.

Regards,



Emeritus Professor Roger Moltzen MNZM
Chairperson
University of Waikato Human Research Ethics Committee