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Burnout in psychological therapists: Is quality of supervision a factor?

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Burnout in psychological therapists: A cross-sectional study investigating the role of supervisory relationship quality

Abstract

Background: Burnout is a growing problem in mental healthcare professionals. Clinical supervision is a mandated part of all psychological therapeutic practice but no previous study has explored whether higher quality supervisory relationships are associated with lower burnout in qualified psychological therapists.

Aims: The study aimed to investigate whether the quality of the supervisory relationship was associated with two facets of burnout, exhaustion and disengagement, in a group of psychological therapists once work demands had been accounted for.

Methods: Psychological therapists were recruited to complete a cross-sectional online survey between May 2016 and January 2017. The survey measured frequency and quality of clinical supervisory relationships, workload factors and disengagement and burnout. Data were analysed using hierarchical linear regression.

Results: Two hundred and ninety-eight qualified psychological therapists responded to the survey. Results suggested that higher quality supervisory relationships were associated with lower disengagement but not lower exhaustion. Frequency of supervision and workload variables were not associated with either facet of burnout. Female gender was associated with higher exhaustion but gender had no association with disengagement. According to previously used cut-off scores, 235 (78.9%) participants could be classed as suffering from 'high burnout', and 173 (58.1%) participants could be classed as suffering from 'high disengagement'.

Conclusions: There is a growing need for burnout reduction interventions in mental healthcare professionals. The present results identify a potential role for enhancing the quality of the supervisory relationship by creating more open, safe spaces for supervisees.

Keywords: Burnout; Supervisory relationship; Supervision; Clinical supervision; Engagement

Key points:

- Burnout is a common problem in psychological therapists, with many experiencing either high exhaustion or high disengagement.
- Higher quality supervisory relationships are associated with lower burnout.

- Enhancing the quality of supervisory relationships may be one route for burnout reduction interventions to consider.

Burnout in Psychological Therapists: A Cross-sectional Study Investigating the Role of Supervisory Relationship Quality

Burnout is a psychological syndrome whereby professionals feel emotionally exhausted by their work and disengaged from their patients (Demerouti & Bakker, 2008). Rather than representing a diagnosable condition, burnout can be regarded as a continuum, with professionals experiencing 'higher' or 'lower' levels (Heinemann & Heinemann, 2017). Burnout was initially popularised as a tripartite concept, comprising exhaustion, disengagement and reduced personal accomplishment (Maslach & Jackson, 1981; Maslach, Schaufeli, & Leiter, 2001), but the latter facet has been found to be less reliably valid than the preceding two (Demerouti et al., 2001). For this reason, more recent burnout models have dropped this from their core conceptualisation (Demerouti & Bakker, 2008; Kristensen et al., 2005). Two key features of work are thought to contribute to burnout; job demands, such as workload and caseload and job resources, such as social support (Maslach et al., 2001).

Rates of stress and burnout in healthcare staff are rising (Shanafelt et al., 2015) and mental healthcare professionals are particularly affected. They report burnout prevalence rates ranging from 21% to 67% (Morse et al., 2012) and their work-related stress and sickness absence rates are consistently higher than those of healthcare staff working in other health sectors (Johnson et al., 2018). Elevated staff burnout has deleterious effects on patient care. It is linked with poorer quality and safety of care across healthcare settings (Hall et al., 2016; Panagioti et al., 2018) and one study in an Assertive Outreach Team found higher staff burnout was associated with a higher probability of patient hospital admissions (Priebe et al., 2004).

Psychological therapists are a growing group of healthcare providers. In Australia, the number of registered Clinical Psychologists has more than doubled in 8 years, increasing from 3907 in 2010 to 8495 in 2018 (Australian Health Practitioner Regulation Agency, 2018). In the UK, the Improving Access to Psychological Therapies initiative (IAPT) has introduced over 6000 newly trained low- and high-intensity therapists to the National Health Service (NHS) since it was launched in 2008 (National Health Service, 2015). The work of psychological therapists involves a high degree of face-to-face client work, which is known to increase risk of burnout (Margiotta et al., 2018), and one study reported that 69% of IAPT therapists met criteria for burnout (Westwood et al., 2017).

The distinct features of the work of psychological therapists mean that contributors to burnout may not overlap with those found in other healthcare professionals. A limited number of studies have sought to investigate causes of burnout in psychological therapists and only a small number of systematic reviews have been conducted (Hannigan, Edwards,

& Burnard, 2004; Lee et al., 2011; Lee et al., 2019; McCormack et al., 2018; Simionato & Simpson, 2018). In an early review, Hannigan et al (2004) focused on burnout in clinical psychologists, and found that high workload, poor quality management and a lack of resources were notable contributors to burnout. Similarly, in a more recent review of studies in applied psychologists, McCormack et al. (2018) found that high work demands were the most significant demand contributing to burnout. McCormack et al. (2018) also explored personal characteristics and work setting, identifying that younger psychologists working in the public sector were at the highest risk of burnout. The remaining three reviews focused on psychotherapists, but reported similar results to those conducted in psychologists. For example, Simionato and Simpson (2018) found that poorer work-life balance, younger age and fewer years of experience were linked with higher burnout levels. Two of these reviews included meta-analyses; together, these meta-analyses provide strong evidence for the role of some types of job demands in contributing to burnout, suggesting that job stress and role conflict are significantly associated with burnout with a medium effect size (Lee et al., 2011; Lee et al., 2019). However, they also identify a lack of knowledge and understanding around the role of job resources in preventing therapist burnout. Lee et al. (2011) examined job support and autonomy as separate categories, and found that whilst autonomy was significantly linked with both exhaustion and disengagement, job support was not significantly linked with either of these burnout facets. Furthermore, only a small number of studies were included in each of these categories, with just four studies exploring autonomy variables and eight studies investigating support. Interestingly, in contrast to previous systematic reviews which did not include meta-analyses, Lee et al. (2019) also reported that the association between caseload and therapist burnout was weak.

Broadly, it is apparent that studies into burnout in psychological therapists have focused more on the investigation of job demands rather than job resources, and there is a need to better understand which job resources may protect therapists from burnout. One potentially useful job resource is clinical supervision. Supervision is a working relationship focused on the education and training of the supervisee with "normative" (e.g. quality control), "restorative" (e.g. emotional processing) and "formative" (e.g. maintaining supervisees' competence) functions (Milne, 2007). In a recently proposed model of the supervisory relationship, Beinart and Clohessy (2015) suggest the quality of the supervisory relationship is central to the wider functions of supervision. They suggest a high quality relationship consists of core relational factors including safety, honesty, connection and positive emotional tone which support the 'flow' of supervision. Regular supervision is mandated by all bodies which accredit psychological therapists (e.g., British Association for Behavioural and Cognitive Psychotherapies, 2019). In Australia, trainee psychologists are required to undertake around 1 hour of supervision for every 17 hours of practice with an

accredited supervisor; registered psychologists are to undertake 10 hours of 'peer consultation', a form of supervision with a more experienced psychologist, every year (Psychology Board of Australia, 2013, 2015, 2017). Maslach (2001) suggests supervision is a key protective factor against burnout. A recent qualitative study in psychological therapists supports this, suggesting that the quality of the relationship in terms of trust and support was particularly important (Hammond, Crowther, & Drummond, 2018). However, few quantitative studies have investigated the links between supervision and burnout in psychological therapists. Of those which have been conducted, it appears that hours of supervision received each week has no significant association with burnout (Westwood et al., 2017), but that quality of the supervisory relationship does (Swords & Ellis, 2017).

Two clear questions about the potential role of supervision in psychological therapist burnout are apparent. First, the only study we are aware of which has investigated the link between the supervision quality and burnout was conducted in health service psychology doctoral students (Swords & Ellis, 2017) and there is a need to explore whether the quality of the supervisory relationship is also important for qualified psychological therapists. Second, previous studies have focused on an overall composite measure of burnout rather than the two key facets of burnout, exhaustion and disengagement (Demerouti & Bakker, 2008). These facets reflect distinct experiences, with exhaustion primarily capturing feelings of work-related weariness and disengagement capturing experiences of feeling disconnected and distanced from work (Peterson et al., 2011). Previous studies suggest these facets may have differing sequelae, with disengagement more closely associated with intention to leave work (Ford, Swayze, & Burley, 2013; Thanacoody, Newman, & Fuchs, 2014). Potential solutions to these facets also vary, with workload reduction viewed as more important for reducing exhaustion, and increasing job resources such as support and training considered to be more important for reducing disengagement (Demerouti et al., 2000; Johnson et al., 2019). As such, it could be predicted that supervision quality may be more closely associated with disengagement in psychological therapists, but research has yet to establish this.

In order to address these issues, the present study sought to investigate whether the quality of the supervisory relationship was associated with reduced levels of burnout in qualified psychological therapists when work demands had been accounted for. Work demands included in the analysis were working full or part time, the average number of service users seen each week and the average number of hours of direct clinical work completed each week. These were chosen based on demand factors found to increase burnout in previous studies in psychological therapists and other healthcare professionals (Kim et al., 2018; McCormack et al., 2018; Westwood et al., 2017).

In summary, the main aim of this study was to investigate whether the quality of the supervisory relationship was associated with exhaustion and disengagement in a group of psychological therapists, once work demands had been accounted for.

Methods

Participants and Recruitment

Participants were psychological therapists recruited between May 2016 and January 2017. They responded to the measures reported in the present paper as part of a larger survey into therapist wellbeing. They were recruited from UK National Health Service (NHS) organisations, third sector organisations and private organisations via emails from their clinical directors, clinical leads and local collaborators which contained a link to the survey. In addition, the British Association of Behavioural and Cognitive Psychotherapies (BABCP) distributed the recruitment email to their accredited members, and the survey was advertised via Social media. All participants read an information sheet and provided informed consent prior to completing the survey. Participants who were not qualified psychological therapists were excluded. As we used a convenience sampling approach, it was not possible to ascertain why some individuals chose not to participate. The study received ethical approval from the School of Psychology, University of Leeds ethics committee (Ref: 16-0104; approval date 4/4/2016) and NHS approval for recruitment from the Health Research Authority (HRA; approval date 23/5/2016). Participants were offered the opportunity to be entered in to a prize draw to win one of two shopping vouchers worth £50.

Design

The study used a cross-sectional online survey design. It was hosted on Bristol Online Surveys (onlinesurveys.ac.uk). It was reported in line with the STROBE Statement (Supplementary File 1).

Procedure

Participants followed a link to the online survey provided on emails which were circulated to advertise the study or on social media adverts. Here they accessed the information sheet, completed informed consent and responded to measures.

Measures

The survey captured demographic information, information pertaining to workload and information about clinical supervision received. The variables reported in the present paper are taken from a larger dataset which also contained the Professional Quality of Life

Scale (Stamm, 2010), the Brief Resilience Scale (Smith et al., 2008), the General Health Questionnaire (Goldberg & Williams, 1988), professional roles and experiences of working with trauma. As these variables were not pertinent to the present research question, they were not included in the current analyses.

Demographic information. Participants were asked to indicate their gender, age, years in practice and professional background (Clinical Psychologist, Counselling Psychologist, Forensic Psychologist, Psychodynamic Psychotherapist, Nurse Practitioner, Social Worker, Cognitive Behavioural Therapist or Psychiatrist). Participants were also asked to indicate the main therapeutic modality they use (Cognitive Behavioural Therapy, Eye Movement Desensitisation and Reprocessing, Cognitive Analytic Therapy, Compassion Focused Therapy, Acceptance and Commitment Therapy, Psychodynamic, Narrative, Systemic and Dialectical Behaviour Therapy) and the type of service they work in (adult primary care, adult secondary and tertiary care, older adult services, and child and adolescent services). In the UK, primary care is usually the first point of contact for people seeking healthcare, for example, general practices; secondary care is often delivered via hospitals and community outpatient services and provides a higher level of care and tertiary services provide highly specialist healthcare, such as forensic mental health hospitals.

Workload. Participants indicated whether they worked full or part time, the average number of service users seen each week and the average number of hours of direct clinical work completed each week.

Supervision. Participants indicated the frequency of clinical supervision received (weekly/fortnightly/monthly/bimonthly/other); this was only recorded as a measure of supervision frequency and was not used as an indicator of supervision quality. Quality of the clinical supervisory relationship was measured using the nine-item safe base subscale of the Short Supervisory Relationship Questionnaire (S-SRQ; Cliffe, Beinart, & Cooper, 2016). Items include "I felt able to openly discuss my concerns with my supervisor" and "My supervisor was open-minded in supervision". Items are rated on a seven-point Likert scale from 'Strongly Disagree' (1) to 'Strongly Agree' (7). Possible total scores range from nine to 63, with higher scores indicating a more collaborative relationship in which the supervisee feels respected and safe (Cliffe et al., 2016). The safe base subscale was chosen instead of the whole scale because it was necessary to ensure the overall survey was as parsimonious as possible, and 1) previous studies suggest the emotional bond between supervisee and supervisor is predicative of overall satisfaction with supervision (Ladany, Ellis, & Friedlander, 1999), and 2) the safe base subscale accounts for 57.45% of the overall variance of the S-

SRQ (Cliffe et al., 2016). The S-SRQ demonstrates acceptable test-retest reliability (r (84)=0.94, p<0.001) (Cliffe et al., 2016) and in the present study the internal consistency of the safe base scale was excellent (α = .97).

Burnout. Burnout was measured using the 16-item Oldenburg Burnout Inventory (OLBI; Demerouti, 2000). This contains two subscales of Exhaustion and Disenagement. The Exhaustion subscale captures the extent to which participants feel exhausted by their work and items include "After my work, I usually feel worn out and weary" and "There are days when I feel tired before I arrive at work". The Disengagement subscales captures the extent to which participants feel disengaged from patients, and items include "Sometimes I feel sickened by my work tasks" and "Over time, one can become disconnected from this type of work". Each item is responded to on a four-point Likert Scale from 'strongly disagree' (1) to 'strongly agree' (4). Possible total scores range from eight to 32 for each subscale, with higher scores indicating a greater degree of burnout. Test-retest reliability has been found to be r=.51 (p<.001) for exhaustion and r=.34 (p<.01) for disengagement over four months (Halbesleben & Demerouti, 2005). The subscales demonstrated good internal consistency in the present study (α = .80 for Emotional Exhaustion and α = .72 for Disengagement).

The scale has not been normed on psychological therapists, but in order to create a binary variable indicating the presence of high burnout, cut-off scores were based on a previous study in a broader healthcare worker population. These identify high burnout as mean item scores of $\geq$ 2.25 on the exhaustion scale and $\geq$ 2.10 on the disengagement scale (Peterson et al., 2008).

Power Analysis

A power calculation was completed using G*power which indicated that 160 participants were required (Faul et al., 2007). This was based on 8 predictor variables, a power of 0.95 and an expected effect size of f^2=0.15.

Analysis Strategy

Missing data analyses were conducted. Rates of missing data were low: 0.7% for age; 0.7% for gender; 1% for years practicing; 0.3% for full-time/part-time working; 1.3% for number of service users per week; 1.3% for hours of direct clinical work per week; 0% for supervision frequency; 0% for each item on the SSRQ and ranging between 0% and 0.7% for each item on the OLBI. Little's chi-square statistic for testing whether values are missing completely at random (MCAR) indicated that that there was no systematic pattern to the

missing data (x=342.69, df=314, p=0.13; Little, 1988). As missing data results in a loss of statistical power, for the purposes of the inferential analyses, means imputation was conducted to replace missing values for the continuous variables. This used the mean of the observed values for each variable (Van der Heijden et al., 2006). The distributions of the workload, supervision and burnout variables were explored using histograms. The supervision variables were skewed and did not conform to normality when relevant transformations were applied to the distributions. So that the supervision variables conformed to the assumptions of parametric tests, we used the continuous data to create binary variables (Field, 2005). The supervision quality variable was transformed using a median split. This involves dichotomising participants in to two groups; those who score above the median and those who score below the median. The supervision frequency variable was dichotomised by grouping responses into two categories (weekly/fortnightly and monthly/bimonthly); responses in the 'other' category were treated as missing. The remaining workload, supervision and burnout variables were either dichotomous (full time/part time working) or did not significantly deviate from the normal distribution. The variables 'number of service users per week' and 'hours of direct clinical work per week' each contained one outlier. These came from the same participant and were unfeasibly high, indicating that the participant had misinterpreted the question. These were treated as missing data and replaced with a means imputation.

All analyses were undertaken in SPSS 22 (Arbuckle, 2013). Initially descriptive statistics were conducted to provide information on participant characteristics. Two hierarchal linear regressions were then undertaken for each of the burnout subscales. Hierarchal linear regression determines which independent variables are significantly associated with a dependent variable while accounting for associations between independent variables (Howitt & Cramer, 2014). In the first step, control variables (age, gender and years practicing) were entered. In the second step, workload variables were entered (full time/part time working, service users seen per week and weekly hours of direct clinical work completed). In the third step, supervision variables were entered (frequency of supervision and quality of the supervisory relationship). Centred variables were used at each step.

Results

Descriptive Information

Participant characteristics. Participant characteristics are reported for raw data prior to means imputation for missing data. In total, there were 319 participants. However, two participants were excluded due to not providing any data and 19 participants were

excluded due to not meeting the inclusion criteria of being a qualified psychological therapist, resulting in a final sample of 298 participants. For full characteristics of the sample, please see Table 1. In brief, the majority of participants were female (n = 235; 78.9%), n = 61 (20.5%) were male, with a mean age of 41.85 (SD = 9.54) years. Participants had been practicing as a psychological therapist for an average of 11.65 years (SD = 7.91), and most were Clinical Psychologists (n = 172; 57.7%) or CBT therapists (n = 63; 21.1%) by background. The most common therapy modalities used were Cognitive Behaviour Therapy (n = 153; 51.3%) and Eye Movement Desensitisation and Reprocessing (n = 31; 10.4%) and most participants worked in adult secondary and tertiary care services (n = 162; 54.3%) or adult primary care (n = 48; 16.1%).

Workload. Most participants were employed on a full-time basis (n = 189; 63.4%); 108 were on a part-time contract (36.2%) and data was missing for one participant (0.3%). Participants saw between 0 and 35 service users per week, (m = 12.21; SD = 6.15; data missing for five participants) and engaged in between 0 and 31 hours of face-to-face clinical work per week (m = 13.30; SD = 5.90; data missing for five participants).

Supervision. Most participants received supervision monthly or bi-monthly (n = 166; 55.7%); 125 received weekly or fortnightly supervision (41.9%) and data was missing for seven participants (2.3%). Scores on the safe base subscale of the S-SRQ ranged from 9 to 63, with a mean of 56.81 (*SD*=56.81).

Burnout. Total scores on the Exhaustion subscale of the OLBI ranged from 9 to 30, with a mean of 19.05 (*SD* = 3.58). Total scores on the Disengagement subscale of the OLBI ranged from 8 to 27 with a mean of 17.04 (*SD* = 3.32). According to previously used cut-off scores, 235 (78.9%) participants could be classed as suffering from 'high exhaustion', and 173 (58.1%) participants could be classed as suffering from 'high disengagement'.

Supervision and Disengagement

The first hierarchical regression analysis investigated whether the frequency and quality of supervision was associated with disengagement above the variance explained by workload and control variables (Table 1). Once control variables (age, gender and years practicing) and workload variables (full time/part time working, service users seen per week and weekly hours of direct clinical work) had been entered, the supervisory variables added significant variance to the model (ΔR^2 = 0.021, p = 0.045). Of the two supervisory variables, only the quality of the supervisory relationship had a small but significant independent association with disengagement (β = -0.136, p = 0.021), supporting the importance of the

supervisory relationship in relation to this aspect of burnout. In contrast, neither the addition of the control variables or the workload variables added significant explanatory variance to the overall model (ps > 0.05). Of the individual variables, only age had a significant independent association with disengagement in the first model (β = -0.161, p = 0.05). However, in the second two models, when other variables had been included in the model, this was no longer significant (ps > 0.05).

Table 1: *Participant characteristics*

		N	%	M	SD	Range
Gender	Female	235	78.9			
	Male	61	20.5			
	Missing	2	0.7			
Age		296	99.3	41.85	9.54	25-69
	Missing	2	0.7			
Years practicing				11.65	7.91	1-40
	Missing	3	1			
Professional background	Clinical Psychologist	172	57.7			
	CBT Therapist	63	21.1			
	Counselling Psychologist	16	5.4			
	Nurse Practitioner	13	4.4			
	Psychodynamic Psychotherapist	6	2			
	Forensic Psychologist	5	1.7			
	Psychiatrist	3	1			
	Social Worker	1	0.3			
	Other	19	6.4			
	Missing	0	0			
Main therapy modality	CBT	153	51.3			
	Eye Movement Desensitisation and Reprocessing	31	10.4			
	Cognitive Analytic Therapy	21	7			
	Psychodynamic Therapy	20	6.7			
	Compassion Focused Therapy	10	3.4			
	Systemic Therapy	8	2.7			
	Dialectical Behaviour Therapy	8	2.7			
	Acceptance and Commitment Therapy	5	1.7			
	Narrative Therapy	2	0.7			
	Other	39	13.1			
	Missing	1	0.3			
Service type	Adult secondary and tertiary care	162	54.3			
	Primary care	48	16.1			
	Child and adolescent	26	8.7			
	Older adult	7	2.3			
	Other	47	15.8			
	Missing	8	2.7			
Full/Part time working	Full-time	189	63.4			
	Part-time	108	36.2			
	Missing	1	0.3			
Weekly clinical hours				13.3	5.9	0-31

	Missing	5	1.7		
Service-users seen per week				12.2	6.2	0-35
	Missing	5	1.7			
Supervision frequency	Weekly	30	10.1			
	Fortnightly	95	31.9			
	Monthly	146	49.0			
	Bi-monthly	20	6.7			
	Other	7	2.3			
	Missing	0	0			
Supervision quality				56.8	8.3	9-63
Burnout	Exhaustion total scale			19.1	3.6	9-30
	Exhaustion item means			2.1	0.4	1-3.4
	High exhaustion	235	78.9			
	Disengagement total scale			17.0	3.3	8-27
	Disengagement item means			2.4	0.4	1.1-3.8
	High disengagement	173	58.1			

Supervision and Exhaustion

The second hierarchical regression analysis investigated whether the frequency and quality of supervision was associated with exhaustion above the variance explained by workload and control variables (Table 2). Once control variables (age, gender and years practicing) and workload variables (full time/part time working, service users seen per week and weekly hours of direct clinical work) had been entered, the supervisory variables did not add significant variance to the model ($\Delta R^2 = 0.008$, p = 0.280) and neither supervisory variable had a significant independent association with exhaustion (ps > 0.05). The addition of the control variables did add significant explanatory variance to the overall model ($R^2 = 0.088$, p < 0.001), but the workload variables did not ($\Delta R^2 = 0.001$, p = 0.963). Of the individual variables, only gender had a significant independent association with exhaustion, and this was present in each of the three models (β = 0.193, p < 0.001, β = 0.193, p = 0.001, β = 0.199, p = 0.001, respectively). This suggested that female gender was associated with higher mean levels of exhaustion (M = 19.48, SD = 3.40) than male gender (M = 17.34, SD = 3.82).

Table 2: *Hierarchical regression analyses predicting burnout facets*

Burnout outcome	Step	Variable Entered	β	Total R^2	ΔR^2
Disengagement	1: Control variables	Age	**-.161***	.028	**.028***
		Gender	.040		
		Years practicing	.013		
	2: Workload variables	Age	-.152	.029	.001
		Gender	.042		
		Years practicing	.004		
		Full time/part time	.004		
		Clinical hours per week	-.009		
		Clients per week	-.027		
	3: Supervision variables	Age	-.161	.051	**.021***
		Gender	.048		
		Years practicing	.002		
		Full time/part time	.004		
		Clinical hours per week	-.010		
		Clients per week	-.015		
		Supervision frequency	.042		
		Supervision quality	**-.136***		
Exhaustion	1: Control variables	Age	-.148	.087	**.087***
		Gender	**.193**		
		Years practicing	-.038		
	2: Workload variables	Age	-.153	.088	.001
		Gender	**.193**		
		Years practicing	-.029		
		Full time/part time	.242		
		Clinical hours per week	-.013		
		Clients per week	.270		
	3: Supervision variables	Age	-.154	.096	.008
		Gender	**.197**		
		Years practicing	-.028		
		Full time/part time	.014		
		Clinical hours per week	-.001		
		Clients per week	.029		
		Supervision frequency	.001		
		Supervision quality	-.091		

Note. *$p \leq .05$, **$p \leq .01$, ***$p \leq .001$.

Discussion

This study used a cross-sectional survey to investigate whether the quality of the supervisory relationship was associated with exhaustion and disengagement, the two key facets of burnout, in a group of qualified psychological therapists. Our results suggested that once control variables and work demands had been controlled for, a higher quality supervisory relationship had a small, significant association with lower disengagement but not lower exhaustion. Frequency of supervision and workload variables were not associated with either facet of burnout. Female gender was associated with higher exhaustion but

gender had no association with disengagement. Most participants scored in the 'high exhaustion' range, and over half of participants scored in the 'high disengagement' range.

This study is the first to explore the potential statistical associations between supervision quality and burnout facets in qualified psychological therapists. The finding that the quality of the supervisory relationship had a significant association with disengagement but not exhaustion is consistent with the predictions of General Model of Burnout (GMB) (Maslach et al., 2001). This model suggests that while workload factors cause exhaustion, inadequate job resources cause disengagement (Maslach et al., 2001). Our discovery of a significant association between the quality of the supervisory relationship and burnout is also in line with a previous study which examined the association between supervision quality and burnout in health psychology doctoral students (Swords & Ellis, 2017). However this previous study only investigated the composite measure of burnout; the present findings show that this association extends to qualified psychological therapists and potentially arises due to the link between quality of the supervisory relationship and disengagement. Disengagement describes experiences of feeling disconnected from services users and is associated with greater intention to leave work (Ford et al., 2013; Peterson et al., 2011; Thanacoody et al., 2014). In an era when burnout in mental healthcare is rising and understaffing is becoming an increasing problem (Care Quality Commission, 2017; Johnson et al., 2018), these findings provide initial evidence of a potential solution in the form of improving supervisory relationship quality. Of note is the fact that supervision frequency was not linked with either burnout facet. Taken together, these results suggest that potential burnout reduction interventions may not require greater input or more time from supervisors, but instead a more supportive approach to this practice.

A large proportion of participants in the present study scored in the 'high burnout' range. These rates were higher than the mixed healthcare population upon which the cut-offs were based, where around a quarter of physicians, a third of nurses and a third of paramedics were categorized as suffering from 'high burnout' (Peterson et al., 2008). However, these rates are similar to those reported by Westwood et al. (2017) who examined burnout in Psychological Wellbeing Practitioners (PWPs) and High Intensity CBT Therapists working in UK primary care. Westwood et al. (2017) reported that most PWPs and around half of CBT Therapists met criteria for burnout (Westwood et al., 2017). Taken together, it appears that the present sample could be considered as high for burnout, but not unusually high compared with other similar practitioners. However, the use of burnout cut-offs has been criticized for variability in the specific criteria used between studies (Doulougeri, Georganta, & Montgomery, 2016); as such, these scores should not be over-interpreted and instead considered together with the overall scale means and ranges.

We found that none of the three workload variables were associated with either burnout facet. This was surprising, as previous systematic reviews (Hannigan et al., 2004; McCormack et al., 2018) and recent studies have suggested that workload, contracted hours and caseload are linked with burnout in psychological therapists (Hammond et al., 2018; Kim et al., 2018). However, these recent studies were conducted outside the UK, and the present findings could be due to the UK healthcare delivery context, a studies of NHS-based therapists are more consistent with our present findings. For example, in a mixed sample of psychological practitioners working in UK primary care, Delgadillo et al. (2018) found that caseload size and severity were not linked with burnout. Similarly, in a group of PWPs and CBT Therapists, Westwood et al. (2017) found that while overtime was associated with higher burnout in PWPs, there was no association in CBT Therapists. However, in contrast to our findings, Westwood et al. (2017) did find a significant link between hours of patient contact and burnout in both PWPs and CBT Therapists. These previous studies present four possible explanations for our present findings. First is the possibility that the arrangement of NHS services reduces the strength of the association between workload factors and burnout, by standardizing this and reducing variability between therapists. The second possibility is that the psychological therapists in our sample had an adequate amount of autonomy over their workload, such that those therapists with higher work-demands had chosen this and so were less likely to be burnt-out by it. The third possibility is that our particular measures of workload did not effectively tap the underlying construct of work demands for psychological therapists. Delgadillo et al. (2018) favoured this third explanation in their study, but further research would be necessary to establish which types of demands may be most relevant for psychological therapists in the UK. Fourth is the possibility that the association between some workload factors such as caseload and burnout in psychological therapists is weak and unlikely to replicate in every study. Supporting this explanation is a recent systematic review and meta-analysis of 27 studies which found that whilst caseload had a small, significant association with disengagement, it had no significant association with exhaustion (Lee et al., 2019).

In our study, female gender was associated with higher levels of exhaustion but there was no association between gender and disengagement. These findings are in line with the broader literature on exhaustion and disengagement profiles. For example, in a study of 4965 participants from eight different professional groups, (Innstrand et al., 2011) found that in most of these groups, women scored significantly higher on the exhaustion scale than their male counterparts. In contrast, the picture for the disengagement scale was much more mixed, with no clear gender pattern. The authors attributed these findings to the possibility that women carry more responsibility in the home and family life, which creates a "double workload", and to the presence of gender inequality in workplaces (Innstrand et al., 2011).

However, this study did not include psychologists, and studies in this group have been more mixed (McCormack et al., 2018). Two recent studies in psychological therapists found no association between gender and either exhaustion or disengagement (Kim et al., 2018; Westwood et al., 2017). It seems then, that the relationship between gender and burnout is complex and likely to depend upon the presence of moderating factors (McCormack et al., 2018).

Limitations

The study used a cross-sectional design, and as such, no conclusions regarding causality can be drawn. The study used an online survey design and so was unable to monitor response rate; as such the results should not be used to estimate prevalence rates for burnout in psychological therapists. The study was also limited by its focus on the safe-base subscale of the Short Supervisory Relationship Questionnaire (S-SRQ). This decision was made in order to reduce the overall number of questions which participants were being asked, however, the remaining subscales measure the educative (formative) and structural elements (normative) of supervision; inclusion of these would have provided a fuller understanding of the role of supervision quality in relation to burnout.

Implications for Theory, Research and Practice

Supervision is a mandated part of psychological therapeutic practice (British Association for Behavioural and Cognitive Psychotherapies, 2019; British Psychological Society, 2010; Psychology Board of Australia, 2015), but research into the antecedents and outcomes of good supervision has been lacking. The present study suggests that higher supervisory relationship quality is associated with lower burnout in psychological therapists. While no conclusions regarding causality can be drawn, these findings suggest that enhancing the quality of supervisory relationships may be a route for future research testing burnout interventions to focus upon. Rather than increasing the frequency of supervision sessions, our results suggest that the key target for these interventions should be on equipping supervisors to create a "safe space" in supervision where supervisees feel able to be open and honest about their experiences. Such interventions could potentially use a range of approaches, including training, the supervision of supervision, or the enhancement of organizational support for supervision.

In the present study we focused on the quality of the supervisory relationship, from the supervisee's perspective. While the literature on clinical supervision is limited, there is a consensus that in order to deliver high quality supervision, supervisors should hold knowledge both in relation to the area that the supervisee is working in and also regarding the process of supervision itself, including supervision models, theories and research

(Falender et al., 2004). In addition to this, they should have a high level of intrapersonal awareness and interpersonal skill in order to build productive supervisory relationships (Falender et al., 2004). One practical recommendation is that supervisors should seek informed consent with supervisees, in the same way that they would with a therapy client (Thomas, 2007). Similarly, Beinart and Clohessy (2015) recommend that supervisors should use contracting, agenda-setting, information sharing and feedback in order to build a constructive supervisory relationship.

In their model of the supervisory relationship, Beinart and Clohessy (2015) suggest the quality of the supervisory relationship is central, feeding into the supervisee's learning and broader experience. Our current findings support this conceptualization by suggesting that the quality of the supervisory relationship may be a resource for broader supervisee wellbeing. However, further research is needed to understand the specific components of supervision which are linked with a stronger supervisory relationship and which may have the potential to reduce supervisee burnout. In particular, it would be useful for future research to investigate whether the format of supervision delivery, in regards to whether it is delivered individually or in groups, and whether a review of tapes is included, is linked with level of burnout in supervisees.

There is also a need for greater understanding around the factors which are associated with lower burnout in psychological therapists. The present results support recent studies in suggesting that a majority of therapists are burnt-out (Swords & Ellis, 2017; Westwood et al., 2017), however, relatively few studies have investigated the contributing factors. A better understanding of this issue could inform the development of feasible, acceptable burnout interventions for this group. Such research could usefully focus on understanding the role of personal characteristics such as coping styles and resilience and job characteristics such as responsibilities, stressors and personal demands, in addition to exploring the role of job resources such as supervision.

Conclusion

This study used a cross-sectional survey design to conduct the first study exploring the relationship between supervisory relationship quality, supervision frequency and burnout in qualified psychological therapists. While supervision frequency was not associated with either facet of burnout, supervisory relationship quality had a small but significant association with lower disengagement. These findings suggest that enhancing supervisory relationship quality may be one route to tackling the problem of burnout in psychological therapists, though further research would be necessary to confirm this.

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